

CHILD PROTECTION TEAM

PROGRAM HANDBOOK



child protection team
Children's Medical Services



Florida Department of Health
Children's Medical Services
Child Protection Team Program
4025 Esplanade Way
Tallahassee, Florida 32399
(850) 245-4200

Child Protection Team Program Handbook

Table of Contents

CHAPTER 1: PURPOSE AND ROLE.....	1
1.1 PURPOSE	1
1.2 SCOPE	1
1.3 AUTHORITY	1
1.4 MISSION AND PROGRAM ORGANIZATION.....	1
1.5 VISION AND VALUES.....	2
1.6 CHILD PROTECTION TEAM PROGRAM OBJECTIVES	2
1.7 BACKGROUND.....	3
1.8 ELIGIBILITY AND TARGET GROUP.....	3
1.9 FUNDING.....	4
1.10 TEAM AVAILABILITY AND ACCESS	4
1.11 DEFINITIONS	5
1.12 CPT HANDBOOK REVISIONS	5
CHAPTER 2: PROGRAM ORGANIZATION	6
2.1 CMS PROGRAM OFFICE	6
2.2 STATEWIDE CHILD PROTECTION TEAM MEDICAL OVERSIGHT	6
2.3 TEAM COMPOSITION	6
2.4 PERSONNEL QUALIFICATIONS AND RESPONSIBILITIES	7
2.5 ABUSE REPORTING AND PROTECTIVE INVESTIGATION RESPONSIBILITIES	8
CHAPTER 3: CASE MANAGEMENT ACTIVITIES	9
3.1 MANDATORY REFERRALS.....	9
3.2 ABUSE REPORT REVIEW PROCESS	10
3.3 CHILD PROTECTION TEAM REFERRAL	13
3.4 CHILD PROTECTION TEAM CASE.....	14
3.5 OPENING A CASE	15
3.6 CASE PROGRESS NOTES	17
3.7 ASSESSMENT ACTIVITY REPORTS	17
3.8 SUPERVISORY CASE REVIEW	21
3.9 CASE CLOSURE	21
3.10 CROSS TEAM CASES	22
3.11 DOCUMENTATION OF PHOTOGRAPHS AND TAPES	23
3.12 RECORD MANAGEMENT AND REPORT CONFIDENTIALITY.....	24
3.13 RETENTION OF RECORDS	25
3.14 TEAM LOGS	25
CHAPTER 4: CHILD PROTECTION TEAM SERVICES.....	26
4.1 ASSESSMENT PROCESS.....	26
4.2 ASSESSMENT ACTIVITIES	28
4.3 STAFFINGS	38
4.4 COURT ACTIVITY – TESTIMONY OR DEPOSITION	39
4.5 OTHER CHILD PROTECTION TEAM ACTIVITIES	40
CHAPTER 5: PROGRAM STANDARDS AND QUALITY ASSURANCE.....	40
5.1 STANDARDS AUTHORITY	40
5.2 PERFORMANCE STANDARDS	40
CHAPTER 6: CHILD PROTECTION TEAM INFORMATION SYSTEM.....	49
6.1 CHILD PROTECTION TEAM INFORMATION SYSTEM (CPTIS).....	49

6.2	SYSTEM SECURITY	49
6.3	SYSTEM SCREENS	49
APPENDIX A:	.....	52
	PERSONNEL QUALIFICATIONS AND RESPONSIBILITIES	52
APPENDIX B:	.....	59
	ADMINISTRATION	59
APPENDIX C:	.....	77
	GLOSSARY	77
APPENDIX D:	.....	81
	EARLY STEPS (ES) CHECKLIST	81
APPENDIX E:	.....	84
	INTERAGENCY AGREEMENT	84
APPENDIX F	.....	90
	STD PROTOCOLS	90
ATTACHMENT I:	.....	112
	CPT TELEMEDICINE NETWORK GUIDEBOOK	112

CHAPTER 1: PURPOSE AND ROLE

1.1 Purpose

This handbook establishes policies, guidelines, and practice for the Department of Health, Children's Medical Services, Child Protection Team (CPT) program's response to reports of child abuse and neglect, and the coordination with child protection staff of the Department of Children and Families (DCF) and designated local sheriff's offices (SO) responsible for child abuse investigations, community-based care (CBC) providers, and law enforcement (LE). These policies, and the program-specific definitions and procedures for program operation, establish consistent standards and expectations for all Child Protection Teams and for community providers who render services purchased by the Child Protection Teams.

1.2 Scope

The Child Protection Team Handbook is applicable to all Child Protection Teams in Florida. It should be utilized in conjunction with the contracts negotiated between the department and individual providers. Specific areas addressed in this handbook include program objectives, roles and responsibilities, service delivery, practice, quality standards, information systems and program administration.

This handbook supersedes all previous policy memoranda and operating procedures distributed to the teams by the Department of Health, Children's Medical Services Program Office.

1.3 Authority

Section 39.303, Florida Statutes, provides for the establishment and maintenance of one or more Child Protection Teams in each of the DCF Regions. Chapter 64C-8, Florida Administrative Code, establishes specific definitions, standards, policies, and procedures for the operation of the Child Protection Team program.

1.4 Mission and Program Organization

The mission of the Department of Health (DOH) is to protect, promote & improve the health of all people in Florida through integrated state, county, & community efforts. The Children's Medical Services (CMS) Program in the Department of Health consists of Network and Related Programs which provides a statewide managed care service system for children with special health care needs, and the Bureau of Child Protection and Special Technology, which is the bureau responsible for the statutorily mandated Child Protection Team Program. The following mission statement focuses the activities of the bureau on the delivery of healthcare services for abused, abandoned, and neglected children.

"To promote the safety and well being of Florida's children by providing medically led multidisciplinary assessment services for children suspected of being abused or neglected."

1.5 Vision and Values

In conjunction with the DOH emphasis on quality improvement efforts, the Bureau of Child Protection and Special Technology established the following core set of values to guide the work of the bureau:

Accountability. We are committed to delivering quality services, producing positive results and achieving customer satisfaction. We take full responsibility for our behavior and for the performance of our job responsibilities.

Collaboration. We forge partnerships with other community, state and federal agencies to strengthen and enhance the services we provide.

Community Diversity. We recognize the uniqueness of each community and are committed to providing services that are flexible in design and responsive to the needs of individual communities while maintaining quality standards through the use of a data driven continuous improvement process.

Innovation. We support exploring new, more efficient and effective ways of doing business through advanced technology and improved business practices.

Integrity. We value respect and integrity in our daily work with our fellow employees, the people we serve and our communities. We do not allow our personal biases to influence our professional judgment.

Teamwork. Our most valuable asset is a dedicated, well-trained staff, working together to meet any challenge. We respect differences of opinion and recognize that the best ideas result from open and honest communication.

1.6 Child Protection Team Program Objectives

The Child Protection Team Program operates on the premise that child abuse, abandonment, and neglect is a multifaceted problem requiring a multidisciplinary response to child protective investigations. The purpose of the program is to supplement the child protective investigation activities of DCF or designated sheriff's offices by providing multidisciplinary assessment services to children and families involved in child abuse and neglect investigations. Child Protection Teams may also provide assessments to Community Based Care providers to assist in case planning activities, when resources are available.

The teams' comprehensive multidisciplinary assessment activities are critical in identifying and evaluating child abuse, abandonment, and neglect, in recommending effective interventions and treatments, and in securing successful long-term outcomes for children and families. Consistent with the legislative intent of the program and with the Department of Health's mission, the objectives of the Child Protection Team Program include:

- Prevention of child abuse and neglect is promoted through consultation with other agencies, training of professionals, and educating the public;
- Identification of child abuse and neglect is promoted through assessment activities that focus on child maltreatment and safety and risk factors; and

- Intervention in child abuse and neglect is promoted through multidisciplinary staffings, expert court testimony, direct service referrals and recommendations that support child safety.

1.7 Background

In 1971, s. 827.07, F.S., mandated reporting of suspected child abuse and neglect. This resulted in a large increase in abuse reports to be investigated by the state. The statute required that child abuse investigators “include a determination of harm or threatened harm to each child, the nature and extent of present or prior injuries, abuse, or neglect, and evidence thereof.”

The Department of Health and Rehabilitative Services recognized the need for a specialized medical resource and made a commitment to provide this under the auspices of the Children’s Medical Services Program. This plan culminated in a legislative appropriation in 1978 to fund a pilot project using a medically led, multidisciplinary team approach.

The success of the first Child Protection Team established in Jacksonville in 1978 led to the establishment of four additional teams in 1979, and between 1981 and 2010, 20 additional teams were added through out the state. Pediatric medical direction was added in 1983 to coordinate the activities of the Child Protection Team Program. By the fall of 1995, a network of teams throughout the state provided each HRS district with this resource. In addition to the evaluation of physical abuse and neglect, the teams became the focal point for expertise in the medical examination of sexually abused children and the evaluation of sexual abuse allegations.

Legislation in 1997 required that the Department of Children and Families and Department of Health develop an interagency agreement specifying the roles of each department. Section 415.5055, Florida Statutes, (now s 39.303 F.S., first paragraph) was further amended in 1998 to provide that the continuing interagency agreement specify how coordination of services was to occur, joint oversight by the two departments, and how joint oversight was to be implemented.

In 1999, as a result of concerns regarding several serious child abuse deaths, the legislature established mandatory criteria for the referral of cases from child protection staff to the Child Protection Teams and expanded the role of the teams to include the review and assessment of all child abuse, abandonment and neglect reports made to the Abuse Hotline to identify those reports meeting the mandatory criteria. Section 39.303, Florida Statutes, provided that child abuse, abandonment, and neglect reports must be referred to the Child Protection Teams for medical evaluation and available support services if the reports involved met the criteria. Additionally, the legislation specified that all abuse, abandonment and neglect reports transmitted for investigation to the local service area by the Florida Abuse Hotline must be simultaneously transmitted to the Department of Health, Child Protection Team for review. All reports must be reviewed by the team coordinator (or designee) and by the medical director (or medical designee). A designee is someone who meets the position requirements and is able to perform the functions in the absence of the individual identified.

1.8 Eligibility and Target Group

The existence or suspicion of child abuse, abandonment, or neglect by an adult caretaker that has been reported to the Florida Abuse Hotline and accepted for investigation provides automatic eligibility for Child Protection Team assessment activities. Specific Child on Child

sexual abuse reports to the hotline are also eligible for referral to Child Protection Teams. There are no financial criteria for determining eligibility for team services.

The target groups for whom Child Protection Team assessment activities are appropriate include physically abused children (particularly those 0-5 years of age), sexually abused children, and children who lack health care (such as medically neglected children). Section 39.303(2), Florida Statutes, identifies specific children and maltreatments mandated for referral to the teams; however, the law does not limit referrals to those specifically mandated.

1.9 Funding

The Child Protection Team Program is funded by the legislature through the Department of Health, Children's Medical Services office. The department, through the CMS program office, contracts with local providers for team services. Providers currently under contract with the department include non-profit agencies, hospitals, universities, and county government.

A. Funding for Initial Medical Exams.

Section 39.304(5), Florida Statutes, provides that counties "in which the child is a resident shall bear the initial costs of the examination of the allegedly abused, abandoned, or neglected child; however, the parents or legal custodian of the child shall be required to reimburse the county for the costs of such examination, other than an initial forensic physical examination, and to reimburse the department for the cost of the photographs taken."

B. Third Party and Other Funding Sources.

Child Protection Teams are required to bill Medicaid or other third party sources for eligible services and are encouraged to seek other third party revenue resources. Program revenue from all sources is to be utilized for the CPT program budget. Child Protection Teams may not bill for expert medical, psychological, and related professional testimony in dependency cases, as this is a service identified in Section 39.303 (1)(e), Florida Statute.

1.10 Team Availability and Access

A. Availability of Services.

Child Protection Teams provide assessment services to supplement the child protective investigation activities of DCF and designated sheriff's offices. They also provide assessments for case planning and service activities to investigators and Community Based Care agencies. These activities are provided in each DCF region. Teams serving large geographical areas have established satellite locations for better accessibility of services or have designated days where they work at remote sites. Team services must be available 24 hours a day, seven days a week, for consultation by phone, or immediate medical diagnosis and evaluation, when indicated.

A listing of the main Child Protection Team offices, the counties they serve, the names of the team's medical director and team coordinator, and a map that shows where the teams are located, can be found on the CPT website: www.cms-kids.org.

B. Access to Team Services.

Initial contact comes primarily from Child Protective Investigators (CPIs) employed by either DCF or the local sheriff's office (SO). However, a team may initially be contacted by another source such as law enforcement, a hospital, or a Community Based Care provider. Regardless, the team must verify that an abuse report has been made and then work in tandem with the designated CPI throughout the investigative phase. If a report has not been made to the Hotline, and the team has reasonable cause to suspect that a child has been abused or neglected, the team member is mandated to make a report to the Hotline at 1-800-96-ABUSE.

C. Telemedicine

In 1998 the Child Protection Team Program implemented a telemedicine project, linking "hub" Child Protection Teams with remote or satellite CPT offices, or local facilities such as hospital emergency rooms, county health departments or child advocacy centers.

The telemedicine network facilitates child abuse, abandonment, and neglect assessments via advanced telecommunications technology between hub sites and remote sites. Each hub site is responsible for electronically providing expert levels of medical child abuse assessments to specific remote sites. The equipment has a minimum of two cameras that allow professional medical staff remotely viewing the interaction to see magnified dermatological examinations as well as observing interactions occurring in the examination room. The camera is able to provide quality views of loop marks, bruises, abrasions, as well as genitalia examinations. Colposcopic exams are also performed by attaching the colposcope's camera to the telemedicine unit. A personal computer integrated into the unit allows storage of images, short audio, video clips, and other assessment data, which can be retrieved at a later time.

The Telemedicine Guide is located, as Attachment I, to this handbook.

1.11 Definitions

Definitions of terms used in this handbook can be found in the Glossary (Appendix C)

1.12 CPT Handbook Revisions

The CPT Program Handbook will be reviewed and any required revisions made once a year. The updated handbook will be posted on the CPT Website. Additionally, any programmatic revisions or updates will be distributed to the CPT providers and posted on the website. These revisions will be incorporated into the handbook during the next revision.

CHAPTER 2: PROGRAM ORGANIZATION

2.1 CMS Program Office

The Department of Health, Children's Medical Services Program Office has oversight and contract management responsibility for the Child Protection Team Program. Specific responsibilities include:

- Ensuring that the Child Protection Team Program is implemented according to legislative intent and as provided in state law, rules, and regulations
- Establishing program standards and performance objectives
- Managing contracts for the Statewide CPT Medical Director and individual Child Protection Teams
- Reviewing, monitoring, and ensuring compliance with statewide standards and performance measures
- Maintaining an automated information system to provide an electronic case file and management data needs
- Statewide supervision of the administration of the Child Protection Team program, including but not limited to:
 - Identifying statewide program needs and recommending solutions and priorities
 - Technical assistance for the medical directors, team coordinators, and staff of the Child Protection Teams
 - Monitoring individual teams to ensure uniform program quality
 - Developing workload and productivity standards
 - Developing resource allocation methodologies
 - Compiling reports, analyses, and assessments of individual and statewide team data

2.2 Statewide Child Protection Team Medical Oversight

Children's Medical Services contracts with a statewide medical director who has expertise in the field of child abuse, abandonment, and neglect, to provide medical oversight for the teams and the team medical directors throughout the state. The Statewide CPT Medical Director provides these oversight functions in coordination with the Bureau of Child Protection and Special Technology and under the direction of the Children's Medical Services Deputy Secretary.

2.3 Team Composition

A. Composition

Each Child Protection Team functions under the oversight of a medical director who is a Children's Medical Services (CMS) approved physician and board-certified pediatrician with expertise and training in child abuse and neglect. The daily coordination of CPT activities is the responsibility of the team coordinator. Case coordinators, varying in number depending on the size of the team, arrange and provide the direct, individual case assessment activities.

All teams have available (on a consultant basis or as paid staff) a Florida licensed team psychologist with experience in the evaluation and treatment of child abuse and neglect and a team attorney who is a member of the Florida Bar, to provide legal services and consultation to the team on a part-time basis. Other CMS physicians, advanced registered nurse practitioners (ARNPs), physician assistants (PAs), attorneys, psychologists, or psychiatrists are available as

needed or appropriate for consultation and diagnosis and evaluation. All CPT medical providers must be approved by the CPT Medical Director and the Statewide CPT Medical Director. Additionally, they must be a CMS approved physician or physician extender. Team psychologist also must be CMS approved providers. Subcontracts for all CPT services must be approved by the CMS Division Director or their designee.

B. Staffing Changes

The Child Protection Teams must notify the contract manager in writing immediately of staff vacancies, funded in full or part by the DOH contract. The contract manager must be immediately notified if the position of team coordinator is vacated. Changes to the Team Coordinator or Case Coordinator positions must be coordinated with, and have the concurrence of the Child Protection Team Medical Director. Staffing updates that include all staff changes must be provided to the contract manager in the quarterly performance measures report and conference calls. Resumes of case coordinators must be submitted to the program office contract manager at the time of hire or prior to if there are questions regarding qualifications. Team coordinators who have questions regarding hiring procedures should contact their contract manager for guidance and assistance.

Prior to filling the vacant team coordinator position, the provider is to send the applicant's resume to the program office for review and concurrence that the individual meets the requirements of the position.

2.4 Personnel Qualifications and Responsibilities

Chapter 64C-8, Florida Administrative Code, addresses the staffing requirements and waiver process for Child Protection Teams. Beyond those professionals required by rule, the teams determine the number and types of positions necessary to the performance of the annual contract. Staff in any additional position, such as program manager or clinical supervisor, that is delegated responsibilities of a required position, must meet the qualifications of that position or have an approved waiver.

The required qualifications, duties and responsibilities associated with each position employed or contracted for the Child Protection Team are listed in Appendix A. Depending on specialized needs in their area, additional duties or responsibilities may be identified by each team.

A. Background Screening

Providers will not be able to employ applicants for positions of special trust or responsibility, as defined in F.S. 110.1127(3)(a), until the applicant is cleared by Level 2 background screening, per F.S. 435.04 (1), the fingerprint based search of criminal records in Florida and nationally. Additionally, volunteers working with the program 10 hours or more a month will require Level 2 background screenings. These requirements are not retroactive for current staff, subcontractors or volunteers; however, will apply once they are required to be rescreened by existing law. Pursuant to Section 408.809 F.S., a background rescreening will be completed for individuals who fall under the Section 435 requirements.

If an individual, who is being considered for hire has been employed with DOH and a background screening was completed in the last five years, the individual will obtain a copy of the background screening results and provide to the hiring agency.

Individuals who work for DOH and are being hired/subcontracted to perform CPT services, must complete the DOH "Outside Employment" form and send to the DOH contract manager. The form will be forwarded to personnel for review and approval. This must occur prior to employment with the provider agency.

2.5 Abuse Reporting and Protective Investigation Responsibilities

A. Mandatory Reporting Requirements.

Section 39.201, Florida Statutes, requires that any person who knows, or has reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver, or other person responsible for the child's welfare, shall report such knowledge or suspicion to the Florida Abuse Hotline. Reports may be made by calling the toll free number (1-800-96-ABUSE) or by faxing a written report to 1-800-914-0004 with all necessary information, including reporter's name and contact telephone number or Fax number.

The Hotline determines the initial level of response (immediate or 24 hour) needed, based on the nature of the allegations and age of child. Cases of suspected child abuse, abandonment, or neglect by an adult caretaker accepted as a report for investigation by the Hotline are electronically transmitted to the appropriate DCF circuit/region or designated sheriff's office responsible for the child protection investigations.

B. DCF and Sheriff's Offices' Roles and Responsibilities

Upon receipt of a report alleging child abuse, abandonment or neglect, child protection staff is responsible for identifying and referring all appropriate children to the Child Protection Team for assessment services. Additionally, each DCF circuit administrator is responsible for appointing a liaison from the circuit/region to work with the local Child Protection Team to ensure that issues and problems are identified and resolved quickly. Community-based providers of child protection services and sheriff's offices responsible for child protective investigations should be encouraged to appoint a liaison to work with the local Child Protection Team.

CHAPTER 3: CASE MANAGEMENT ACTIVITIES

3.1 Mandatory Referrals

A. Mandatory Criteria

Subsection 39.303 (2), Florida Statutes, specifies the types of cases that must be referred by CPIs to the Child Protection Teams for assessment and other appropriate available support services. Mandatory referral cases include those involving:

- Injuries to the head, bruises to the neck or head, burns, or fractures in a child of any age
- Bruises anywhere on a child five years of age or younger
- Any report alleging sexual abuse of a child.
Sexual Abuse Threatened Harm is not mandatory. Victims of child on child sexual abuse, or alleged juvenile sexual offenders (children 12 years of age or younger) may be accepted for team services but are not mandatory referrals
- Any sexually transmitted disease in a prepubescent child
- Reported malnutrition of a child and failure of a child to thrive
- Reported medical neglect of a child
- Any family in which one or more children have been pronounced dead on arrival at a hospital or other health care facility, or have been injured and later died, as a result of suspected abuse, abandonment, or neglect, when any sibling or other child remains in the home
- Symptoms of serious emotional problems in a child when emotional or other abuse, abandonment, or neglect is suspected

Human trafficking cases are also eligible for CPT assessment services, though not mandatory.

B. Exceptions to the Mandatory Medical Evaluation Criteria

A child meeting the mandatory criteria for Child Protection Team referral may be exempt from a face to face medical evaluation, as defined in subsection 39.303 (4) Florida Statute, under the following circumstances:

- The child was examined for the alleged abuse or neglect by a physician who is not a member of the Child Protection Team, and a consultation between the Child Protection Team medical professional and the examining physician concluded that further medical evaluation was unnecessary.

Guidelines:

Emphasis should be placed on the requirement that the CPT medical professional has consulted with the examining physician and concluded that further medical evaluation was unnecessary. The CPT Case Coordinator should still determine if other CPT assessment activities are appropriate.

- The CPI, with supervisory approval, determined after conducting a child safety assessment that there were no indications of injuries meeting the criteria in Section 3.1, paragraph A.

Guidelines:

*The DCF or the designated sheriff's office can only request an exception to a medical evaluation when a child has **no injury** meeting mandatory criteria, but this exception can not be used when alleged abuse or neglect would not result in a visible injury. Notwithstanding the above, the CPT medical director can still require a child be referred if they think a medical evaluation is needed. Under no circumstances should any child with injuries meeting mandatory criteria be identified as a DCF or SO exemption from a face to face medical evaluation.*

- The Child Protection Team board-certified pediatrician determined that a medical evaluation was not required.

Guidelines:

This should not be used to exempt a case from a medical evaluation solely because a child's injuries are believed to be adequately explained by the CPI. It should be used judiciously, only in cases when the CPT physician is certain that the child could not benefit from a medical evaluation. At a minimum, the CPT should consider prior reports, and determine if substance abuse, domestic violence or other high risk factors are indicated before granting this medical evaluation exception. The CPTIS Intake/Referral screen will record what information was considered and generate a report to be sent to the CPI documenting the rationale for the exception. The CPT Case Coordinator should still determine if other CPT assessment activities are appropriate before closing case after intake.

All cases involving mandatory criteria must be referred. An exception to the criteria for mandatory medical evaluation does not preclude the acceptance of a referral, if other assessment services offered by the team are appropriate. If an exception to a face to face medical exam is granted the team can complete the Intake/Referral Screen in CPTIS and provide the Intake report to the CPI. The Intake/Referral is closed after intake if no other team assessments are needed. Team Coordinators and Supervisors must review all Intake/Referral reports that are closed with no assessment services in CPTIS to ensure that data is in compliance with Florida Statute and the CPT Handbook.

A CPT pediatrician may determine that a face-to-face medical evaluation would benefit a child with allegations not meeting the mandatory criteria. In these cases, the abuse review screen should indicate that a medical is needed; however, the case should not be coded as a mandatory referral. Teams should accept referrals on non-mandatory cases when the child would benefit from team assessments.

3.2 Abuse Report Review Process

A. Medical Director and Team Coordinator Responsibilities

Section 39.303(3), Florida Statutes, states that all abuse and neglect cases transmitted for investigation to a district by the Hotline must be simultaneously transmitted to Child Protection Teams for review. Medical director and team coordinator responsibilities for the abuse report review process include:

- Working with local child protection staff to establish protocols that ensure all reports to the Hotline are received by the team for review.
- Ensuring the review of all received abuse reports to determine if they meet the mandatory referral criteria as outlined in s. 39.303 (2), F.S. The medical director (or medical designee) **and** the team coordinator (or designee) must complete this review.
- Ensuring the review of all reports to the Child Protection Team to determine if assessment services or other appropriate available support services are necessary.
- Ensuring that abuse report review data is entered in the Child Protection Team Information System, (CPTIS).

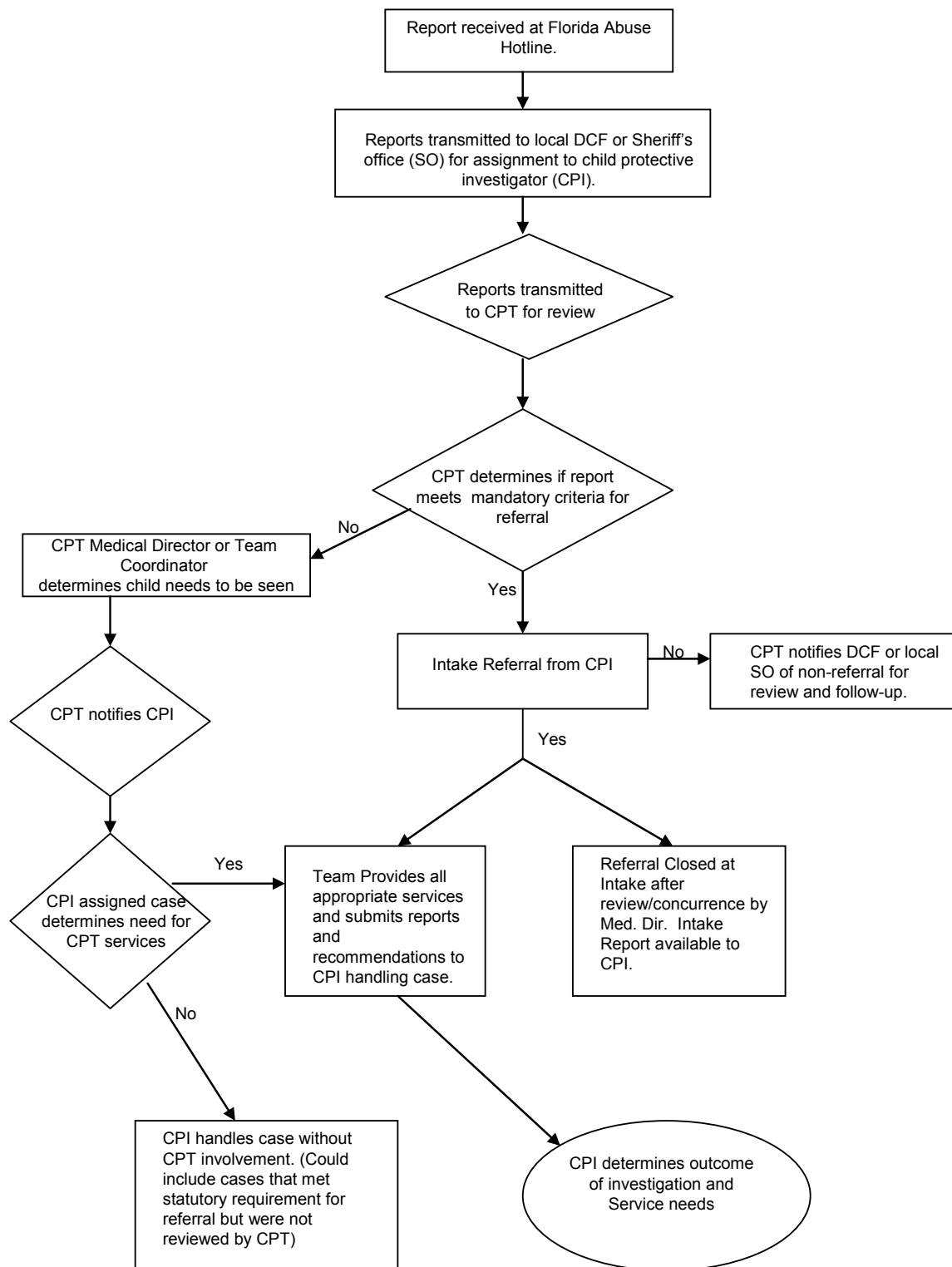
The flow-chart on the following page shows the abuse report review and referral process.

B. Medical Review

The Child Protection Team Medical Director (or designee) must timely review all reports to determine whether a face-to-face medical evaluation by the Child Protection Team is needed. Cases must be reviewed by:

- A physician licensed under Section 458, F.S., or Section 459, F.S., who holds board certification in pediatrics and is a member of a Child Protection Team;
- A physician licensed under Section 458, F.S., or Section 459, F.S., who holds board certification in a specialty other than pediatrics, who may complete the review only when working under the direction of a physician licensed under Section 458, F.S., or Section 459, F.S., who holds board certification in pediatrics and is a member of a Child Protection Team;
- An advanced registered nurse practitioner licensed under Section 464, F.S., who has a specialty in pediatrics or family medicine and is a member of a Child Protection Team;
- A physician assistant licensed under Section 458, F.S., or Section 459, F.S., who may complete the review only when working under the supervision of a physician licensed under Section 458, F.S., or Section 459, F.S., who holds board certification in pediatrics and is a member of a Child Protection Team; or
- A registered nurse licensed under Section 464, F.S., who may complete the review only when working under the direct supervision of a physician licensed under Section 458, F.S., or Section 459, F.S., who holds certification in pediatrics and is a member of a Child Protection Team.

The Medical Director should periodically review the entire process with all medical providers to ensure that the same criteria are used in reaching such determinations.

CPT AND CPI ABUSE REPORT REVIEW AND REFERRAL FLOW CHART - NEW

C. Time Frame for Abuse Report Review

Reports of abuse, neglect or abandonment must be reviewed by the team coordinator (or their designee) and the medical director (or medical designee) within four working days of report receipt or notification. While four working days is the maximum, reports should be reviewed as soon as possible upon receipt.

Teams should send a list of all cases that met the mandatory referral criteria but have not been referred (an Intake/Referral completed by child protection team staff) no less frequently than every four working days. A list of mandated cases not referred is one of the reports available through CPTIS. If the DCF or SO have direct access to CPTIS, an agreement to amend this requirement can be arranged. Any such agreement must be signed by both parties and a copy provided to the CPT contract manager.

D. Restricted Case

A restricted case is one in which a CPT or Family Safety program employee, family member, household member, Sheriff's office staff responsible for child abuse investigations, or provider agency employee is the subject of a FSFN report of abuse, neglect, abandonment or exploitation and the referral is made to CPT, whether services are ultimately provided or not. For the purpose of this section, they shall be called "sensitive" cases. Each provider will immediately notify their CPT contract manager upon learning that a report or referral received meets the "sensitive" guidelines. Steps will be immediately taken to restrict access in CPTIS.

To maintain confidentiality and ensure objectivity (or no conflict of interest occurs), the team coordinator will contact a neighboring CPT and request that the team handle any referral from the child protective investigator for assessment services. The FSFN report and any documented information will be immediately forwarded to the neighboring CPT.

In cases where the CPT or FS employee is the alleged perpetrator of the maltreatment, the individual employee's access to CPTIS and FSFN must be removed by close of business the next working day.

Each team coordinator will be identified, as having the authorization to restrict access to sensitive cases. Team coordinators will be responsible for ensuring that all security and confidentiality measures have been completed. Any violations of confidentiality and security will require notification to the program office and completion of the DOH-1152, Incident Report, which will be forwarded to the contract manager immediately.

3.3 Child Protection Team Referral

A referral is defined as a discussion between the CPI and case coordinator where the allegations, CPI information and prior reports are discussed to determine if CPT assessment services are appropriate. The case coordinator is responsible for the completion of the Intake/Referral Screen for all mandatory reports referred. The Intake/Referral Screen may also be completed for non mandatory referrals as well. The Medical Director (or designee) must review and concur with the decision to not provide medical services in all mandatory reports. For more on the Intake/Referral process, see Chapter 4.2, Assessment Activities.

3.4 Child Protection Team Case

A. Case Requirements

To be accepted as a Child Protection Team case, all referrals to the Child Protection Team must have been reported to the Hotline. If a report has not been made in a case where there is reasonable cause to suspect that the child has been abused or neglected, the Child Protection Team must notify the referring person of his legal responsibilities to make a report to the Hotline and, if enough information is provided, follow-up to ensure that a report is made. If no report is called to the Hotline, the CPT staff person must report it. (See paragraph 2.6 A for an explanation of mandatory abuse reporting requirements)

The referral must include a discussion with the referral source and meet the following criteria for the referral to be considered for CPT services and entered as such in CPTIS:

- All cases referred to and accepted by the CPT must have an abuse report number and involve or have involved a protective investigation.
- Referrals may be accepted for assessment services by Community Based Care (CBC) case managers (providers contracted by DCF) to assist in the identification of family strengths and needs for case planning purposes. These referrals **MUST** occur within 90 days of receipt of the abuse report to the Hotline and can not be for the purposes of assessing new maltreatments. As in the case of a referral from a CPI, the CBC case manager referral will be screened for appropriateness of services requested.
- The child must be a subject in the abuse report, or the case coordinator or CPT medical provider must document that the referring CPI has stated that the child will be added to the abuse report.
- Specific assessment activities must have been agreed upon by the CPT and the referral source and documented in the Intake/Referral Report however, the CPT is not limited to assessments identified by the referral source.
- CPT assessment activities and reports must be entered into CPTIS and the reports, upon completion, provided to the referral source within the contracted required timeframes. The case progress notes in CPTIS must have documentation of when each report was sent. Interim or Final Case Summary reports that include the information from individual assessments do not substitute for individual assessment reports. Combining assessments into one written report does not negate the individual report content or time frame requirements.
- Once all the assessments are completed and the case is closed in CPTIS, a copy of the data system generated Final Case Summary must be provided to the referral source. The case progress notes in CPTIS must have documentation of when the final case summary report was provided.

The Department of Health and the Department of Children and Families have entered into an agreement that provides for designated child protective investigators and supervisors to have access to specific screens for the purpose of viewing and printing CPT reports (Client History, Intake/Referral, Finalized Assessment Reports and Final Case Summary) in CPTIS. For these areas, notification will be made that the report is ready to be printed. This notification will serve as the “date report sent”. Providers throughout the state will need to work with their local child protective investigations offices to ensure clear and timely communication occurs.

The system generated Addendum report must be completed and sent to the referral source for cases that were initially referred by the CPI and closed after CPT assessment were provided and subsequent contact with the CPI or a CBC case manager resulted in additional assessment activities being provided.

Child Protection Team review of the abuse report for the purposes of complying with Section 39.303(2), F.S., does not constitute a referral to the Child Protection Team.

B. Referral Source

CPIs are the primary referral source for Child Protection Team assessment services. Occasionally, the initial referral may come from other involved professionals (e.g., law enforcement, hospitals, and physicians) in situations where an abuse report has been made and an investigation is in progress. As soon as a referral is received from a source other than the CPI during an investigation, the Child Protection Team must contact the assigned CPI to coordinate appropriate team assessment activities.

Additionally, Community Based Care case managers may refer cases to the team that were either referred and closed to CPT, or were not referred during the investigation. The cases are not considered mandatory, even if the original allegations met the mandatory criteria, but can be accepted for assessment services to assist in case planning.

C. Referral Timeliness.

- 1. Timely Referrals.** Timely referrals to the CPT are necessary to ensure an adequate assessment of the alleged injuries to the child. Immediately upon determining that a report meets the mandatory criteria for a face to face medical evaluation, or if other appropriate assessment services are needed, the CPI should contact the local CPT office and discuss the referral with a case coordinator so that appropriate assessment services are identified. Some referrals may require immediate team assessments to identify immediate safety factors and document medical findings of abuse or neglect.
- 2. Late Referrals.** Unless there are extenuating circumstances which justify a CPI late referral to CPT, referrals involving reports open over 60 days or on old allegations, may be considered inappropriate referrals and declined by teams when no team services would benefit the child. The request for a medical examination may be declined if the CPT pediatrician or nurse practitioner has assessed the request and determined that the child would not benefit from a medical evaluation. Declined referrals must be documented in CPTIS.

3.5 Opening a Case

To open a case, assessment activities for the child must be identified and diligent attempts must be made to complete the assessment activities and documented in the CPTIS electronic case record. Opening a case involves completing the Intake and then Registration Screens in CPTIS. Detailed instructions for the CPTIS data entry are included in the CPTIS User Guide.

A. Case Record Documentation

Each child referred to the Child Protection Team for team assessment activities must have an electronic case record that includes documentation necessary to provide a comprehensive record of CPT involvement with the child. When more than one case record is generated as a result of an abuse report in which more than one related victim is accepted for assessment services, case coordinators shall ensure that any recommendations made should be child/victim specific in each child's file.

Clear and accurate documentation of assessment and case coordination activities is essential. Such documentation provides a comprehensive record of CPT involvement with the case and is necessary in order to accurately record:

- Referral information
- Requests for services
- Activities conducted on behalf of the child (e.g., interviews, staffings, medical exams, psychological evaluations, and psychosocial assessments)
- 24 hour notification of positive findings and risk
- When reports were provided to the CPI or CBC case manager

All case activities must be documented in the CPTIS electronic case record.

B. Case Information

The Intake/Referral Screen must be completed, at a minimum, for all mandatory reports referred. However, this screen is required for all abuse reports (mandatory or not mandatory) accepted for CPT assessment services. If an abuse report is not referred for CPT services, the Intake/Referral Screen in CPTIS will serve as documentation of the referral. Information gathered during the intake/referral process shall be documented on the CPTIS Intake/Referral Screen. The discussion between the case coordinator and CPI shall be thoroughly documented and provide appropriate justification for the decision to provide services or not.

The team must ensure that CPTIS and any other records kept by the Child Protection Team are searched to determine if the child has had prior involvement with CPT. If so, the case coordinator should review the Client History Report and available CPT closed files to ensure they have an accurate picture prior Child Protection Team involvement with the child and family.

The case coordinator should verify the accuracy of the information in the abuse report with the CPI or CBC case manager and, if necessary, update the information to reflect any additional maltreatments, social security numbers, additional household members, addresses, and correct spelling of names. Providing the CPI with additional maltreatments or victims does not excuse case coordinators from their statutorily mandated duty to notify the Hotline, unless they verify that the additional maltreatments or victims were added by the CPI and this is documented in the intake/referral. Additional maltreatments can not be reported to CBC case managers. If the case is beyond the investigation stage a new report must be called to the hotline.

The case coordinator should document the results of the investigator's interviews with the subjects, including the identification of who was interviewed, the name of the interviewer, and a statement summarizing the interview information. This information will assist the case coordinator and investigator in identifying needed assessment services.

3.6 Case Progress Notes

The case progress record provides documentation of all case sequence of events that include contacts and activities completed by the case coordinator, or other team members involved in the case. The case progress notes must present a concise history of all activities related to the case.

When medical staff maintain separate medical files, Child Protection Team physicians, ARNPs, physician assistants and nurses must assure their critical case specific contacts are documented and input in the electronic case record.

Case progress notes should be entered into CPTIS at the time of the event or contact. They should indicate objective observations, record events, and make note of actions. Documentation must be thorough, timely and grammatically correct. At a minimum, the electronic case progress notes should:

- Identify the person contacted followed by their role in the case or their relationship to the child/victim If not previously identified.
- Document all contacts (including attempts to contact) made on behalf of the child and any pertinent information shared.
- Clearly document the information provided or shared and the source of the information.
- Document all assessment activities specific to the subject child, including who was present and brief description of the results/findings with reference to written formal reports for additional information. (When there is more than one subject/child receiving CPT services, there may be common contacts which can be shared for all children, i.e. CPT staffing or interview with parent/guardian). Case coordinators should use discretion when documenting case progress notes for each child, to ensure that confidential information concerning one child is not documented in another child's electronic case file.
- Include the dates of request for or receipt of pertinent documents as well as the transmittal of reports and other documents.
- Include documentation of supervisory review and consultation, and non-medical peer review. The case coordinator's follow-up to any recommendations resulting from the supervisor review or an explanation as to why case coordinator was unable to complete the supervisor recommendations (e.g. "Supervisor review indicated need for staffing, however, PI had closed the case.") should also be included. Explanations should be provided for planned activities that did not occur.

3.7 Assessment Activity Reports

A. General Guidelines

Child Protection Teams provide several types of assessments, including CPT and forensic interviews, family social assessments, case staffings, medical exams, and psychological evaluations. Once the assessment activities are completed the case coordinator will generate the individual assessment reports in CPTIS. These reports should accurately record the purpose and nature of the assessment, the date(s) involved, the participants, the

provided history, the child safety/risk, and the conclusions and recommendations. Each CPTIS report screen has fields that will auto populate information pertinent to that assessment activity. These are followed by narrative fields which need to be completed.

- Adults mentioned in the report should be initially referenced by their full names or titles and last names (e.g., Mrs. Mary Smith). Subsequently, adults should be identified by title and last name. If more than one person has the same title and last name, use the first name initial to differentiate.
- Reports should include documentation of CPI or case manager's specific requests.
- For reports that include an assessment of child/family safety and risk factors, (CPT interview and social) the assessment of risk should be comprehensive and family/victim specific.
- Recommendations should be realistic and clear, and, when appropriate, responsible parties and specific time frames identified.
- Reports should be sent only to agencies legally entitled to receive them, and should only be sent on a case specific "need to know" basis.

All Child Protection Team staff should exercise caution when preparing reports. For example, instead of saying a client was drunk, record that the client smelled of alcohol, had slurred speech, or was unable to walk straight, etc. The same can be said for a client who appears to be under the influence of drugs. Observations of their speech, walk, and actions are more appropriate.

Avoid using loaded terminology, such as "the child failed to disclose abuse." This implies that the child failed at something that he or she could have succeeded at, and also implies that the goal was to get a disclosure, rather than to determine what, if anything, happened.

B. Time Frames – Required Reports

Because the primary purpose of the Child Protection Team Program is to supplement the child protective investigation activities of Department of Children and Families or designated sheriff's offices by providing multidisciplinary assessment services to children and families involved in child abuse and neglect investigations, it is essential that CPT staff be aware of, and make every effort to function within, the legal requirements that govern the work of CPIs. Additionally, since CPT will also be accepting referrals from CBC case managers for case planning purposes, meeting those time frames are also essential. The time frames for completion of required CPT reports are consistent with the following time frames in Section 39, F.S., that were established to guide child protection staff and court involvement in the child safety and permanency process:

- | | |
|---|--|
| • Shelter hearing | • Within 24 hours after removal of the child from the home (39.402, F.S.) |
| • Petition filed seeking adjudication that a child is dependent | • Within 21 days after shelter hearing or within 7 days after any party files a demand for early filing – whichever comes first (39.501, F.S.) |
| • Arraignment hearing | • Within 7 days after dependency petition filed (if a demand for early filing) and no later than 28 days after shelter hearing (39.506, F.S.) |

-
- | | |
|---|--|
| <ul style="list-style-type: none"> • Shelter Review Hearing • Adjudicatory hearing • Case plan completed • Case plan filed with court • Disposition hearing and case plan acceptance | <ul style="list-style-type: none"> • No later than 30 days from removal in conjunction with arraignment or as otherwise provided by law or determined by the court (39.402, F.S.) • No later than 30 days after arraignment (39.507, F.S.) • Within 60 days after the removal of the child (39.6011, F.S.) • No less than 3 business days prior to the disposition hearing (39.6011, F.S.) • Within 15 days of arraignment if there was a “consent” or “admit,” or within 30 days after conclusion of adjudicatory hearing if there was a “deny” (39.506, F.S.) |
|---|--|

The concept that should drive report completion is that information must reach CPIs in time to be useful in assisting with decisions to protect the child, and CBS case managers in time to assist them in case planning. In cases where there are issues of child safety (whether this is the conclusion of a medical exam, an interview, or other assessment activity which identified safety issues) the CPI or CBC case manager should be notified immediately. A report is essential to document the information, but information sharing should not be delayed until the report is completed when child safety is an issue. If the safety issue is the result of suspected new maltreatment or threat of harm, a report should be immediately made to the Abuse Hotline in addition to contacting the CPI or CBC case manager.

Although the case progress notes should provide documentation of the ongoing communication with the appropriate information provided, CPT contracts require that the following reports be submitted to the CPI or, when appropriate, the CBC case manager within the following time frames:

- Verbal notification of positive findings from any assessment activity within 24 hours.
- Written medical reports and nursing assessments within 10 working days following completion of examination or assessment.
- Interview reports within 10 working days following completion of the interview.
- Staffing reports within 10 working days following completion of the staffing.
- Social Assessment reports within 20 working days following the completion of the assessment (last scheduled interview).
- Psychological reports within 20 working days following the completion of the evaluation (last interview completed).
- Final Case Summary (CPTIS generated) for all cases at the time of closure.

If assessment reports are combined, they must meet the timeframe of the initial assessment activity report. The date each of these reports was provided to the CPI or CBC case manager must be documented on the case progress notes. Compliance with CPT assessment reports is tracked in CPTIS, so staff must ensure that data is entered in a timely manner.

Most timeframes start the day following the assessment activity. An assessment provided on January 20th would begin with day one being January 21st. When the word “following” is used, the day after the referral’s receipt is counted as the first day.

C. Timely Assessments – Reason for Delay

Team assessment activities should be completed within 20 calendar days following the initiation date, which is the Referral Date on the CPTIS registration screen, (the day after receipt of the referral counts as the first day). Performance on the timely provision of assessments will be tracked through CPTIS. Occasionally, there may be extenuating circumstances which make it impossible to meet the 20 day timeframe. These cases will be exempted from the management reports which document compliance with this performance measure. Reasons for delay that qualify for exemption in compliance measure monitoring are limited to those cases where assessments were delayed because:

- Additional CPT Referral or Information/Assessment – The team has received a request for additional assessment services based on CPI staff or community based provider receiving new information or additional allegations. This does not require a new hotline report.
- Assessment No-Show – The assessment service was scheduled, however, the subject failed to show for the appointment and another appointment has been made.
- Medical No-Show – The medical exam was scheduled, however, the child failed to show for the appointment and another one has been scheduled.
- Waiting for Medical Records: The assessment service required that copies of the child's medical records be received and reviewed.
- Post Termination: The team had closed their case and additional assessment services were requested.
- Delay – Family Not Responsive – The family has failed to respond to CPI or CPT requests to schedule assessment activities within a timely manner.

Reasons for assessment delay must be documented in the case progress notes in CPTIS. If the delay does not meet one of the compliance exemptions, the selection "Late No Exception" should be selected. Since there was not an acceptable reason for delay, the assessment activity will show as not compliant with the required time frames in CPTIS.

When the team accepts a referral from a CBC case manager and the CPI had already referred the case, and assessment services were completed and the case terminated in CPTIS, the case coordinator will complete the Addendum to the Intake/Referral Screen and document the referral discussion and decision to provide CPT services. Any additional services completed will be added as assessments to the terminated registration. The case coordinator will prepare the electronic assessment report and complete the Addendum to the Final Case Summary report and send to the CBC case manager. If the case was not previously referred by the CPI and is accepted for CPT services, it will be entered into CPTIS as a new case and handled with the same required timeframes for applicable assessment reports. Please note that certain CPTIS fields will be disabled when a registration is created from the referral source of CBC case manager. This is due to assessment activities being limited to providing services for case planning, not to supplement the CPI investigation. For additional information please refer to the CPTIS Guide.

For medical consultation cases, an additional exception for "awaiting medical records" is included. The request for records, however, must occur within the 20 day timeframe.

D. Time Frames – Other Reports

Time frames for the provision of assessment activities and reports that are completed by subcontracted providers of the teams must be included in the subcontract or written agreement with the provider. Except for unusual circumstances, subcontracted assessment activities should be received within the time frame necessary to meet performance standards.

3.8 Supervisory Case Review

Supervisory case review is a formalized internal team process for reviewing the content, status, and progress of completing team assessment activities. This review should be done by the team coordinator or clinical supervisor (but may be done by a designated individual who meets the qualifications for team coordinator). While every case requires at least one supervisory review, the frequency of supervisory review should be driven by the complexity of the case and the experience level of the case coordinator. While a more experienced case coordinator may need far less guidance than a less experienced peer, all case coordinators must be provided with an appropriate level of supervision. It is the Team Coordinator's responsibility to determine the frequency of case reviews. All cases remaining open over 45 days shall be reviewed on a more frequent basis, regardless of the experience level of the case coordinator.

Supervisory case reviews will be documented in CPTIS in the case progress notes and include

- Date of review
- Name of the team coordinator or clinical supervisor completing the review
- Concurrence with ongoing case activities, recommendations for additional case activities, or agreement that all case assessment activities have been completed and the case file is ready to close.

Case work concerns that require follow up by the case coordinator should be clearly documented on the supervisory review section of the CPTIS case progress notes.

3.9 Case Closure**A. Guidelines**

The case is ready for closure after all team assessment activities have been completed, all reports of assessments have been provided to the investigator or CBC case manager, all documentation in the electronic case file has been reviewed and approved by the team coordinator or, clinical supervisor, and all pertinent information has been entered into CPTIS. The date the final case summary report is provided to the CPI or CBC case manager is the date of closure (termination) and must be entered on the case progress notes in CPTIS.

In some Child Protection Team cases, closure may occur with no completed assessment activities. These situations may include cases in which the family refuses to cooperate and failed to show for scheduled appointments, such as medical appointments or interviews; or the family left the area. CPIs should be notified immediately when a family fails to show so they can determine the level of intervention needed. In instances where no assessment activities were completed, the team may do one of two things. The first is complete the Final Case Summary which documents the diligent efforts to provide services and contacts attempted regarding the

case. There should be documentation in the CPTIS case progress notes that the supervisor reviewed the reasons for closure and concurred. The second is for referrals that were accepted for services and subsequently withdrawn and not entered as a registration. The Intake/Referral Screen should document the date of the original referral and the reason for closing with no assessment services. If the case meets the mandatory referral criteria, it should be reviewed by the team physician and supervisor for concurrence/approval prior to closing.

B. Time Frame for Closure

All case activities should be completed and cases closed in CPTIS within 60 days following the date of referral. Team coordinators should use the CPTIS caseload report and complete a review of the electronic case records to monitor the number of cases open over 45 days in order to determine the reason and avoid closure backlogs. Cases open over 45 or 60 days should be reviewed and the reason still open documented.

3.10 Cross Team Cases

Typically this is related to children who need specialized medical care which is not available in their local community. The child may or may not be seen, prior to transfer, by the local CPT personnel. Cases like this usually involve assessment services being provided by two different CPTs. For purposes of identification, the CPT Service area where a child lives is referred to as the "local CPT" and the place to which the child was transferred as the "secondary CPT. It is important that the teams communicate with each other to ensure continuity of service to the child and family.

A. The local CPT has primary responsibility:

- 1) For creating the Registration, ensuring all case progress notes, assessments and assessment reports are documented in CPTIS. Also responsible for preparing the Final Case Summary (FCS).
- 2) To provide on-going expertise to the Department of Children and Families (DCF), Community Based Care (CBC), law enforcement (LE), and the State's Attorney Office (SAO) in general, and for questions about the case.
- 3) To interpret the medical and case findings from the secondary CPT to DCF, LE, and the SAO.
- 4) To testify on such cases in their local court, and to document court testimony in CPTIS.
- 5) Coordinating with the secondary team to ensure all report time frames are met and provided to the child protective investigator, law enforcement or state attorney.

The local team may only provide a medical consult on the case if the results of the medical evaluation by the secondary CPT indicate that review of additional medical records are needed to augment the tertiary secondary CPT's medical opinion regarding the allegations of abuse or neglect

B. The secondary CPT assists as needed and is responsible for:

- 1) Providing on-site medical and/or other team assessments as needed

- 2) Providing completed assessment reports in CPTIS to the local CPT within specified time frames that allows the local CPT to meet reporting requirements to the protective investigator.
- 3) Being available by phone to the local team as needed or providing court testimony.
- 4) Documenting all contacts on the case progress notes, assessment activities and assessment reports in CPTIS.

C Travel and Billing

If the physical presence of a secondary team expert is needed in the local CPT district, the travel and testimony expenses for this are borne by the local CPT. Payment for this testimony must be negotiated and agreed upon by both teams. Medical testimony may not be billed to the court or DCF on dependency cases; however medical providers may bill reasonable and customary fees for any testimony in criminal cases.

D. Dispute Resolution

In the event there is a dispute between the two CPT providers that cannot be resolved between the respective Team Coordinators and Medical Directors, the matter should be referred to Children's Medical Services for mediation. Under no circumstances should a dispute interfere with the delivery of Child Protection Team services to a child or their family. The Deputy Secretary for Children's Medical Services is the final authority for resolution of disputes that cannot be successfully mediated.

3.11 Documentation of Photographs and Tapes

When photographs are used to record physical injuries or when child interviews are taped, the photographs and tapes must be clearly labeled and maintained. Labeling is important as it identifies when the activity occurred, who it involved and who completed the activity. Teams should ensure that all photos and medical documents saved electronically are appropriately labeled.

Photographs

Pursuant to Section 39.304(1)(a) F.S., any CPT that examines a child who is the subject of a report must take, or cause to be taken, photographs of any areas of visible trauma on the child. The CPT will provide the photographs or duplicates of the photographs of physical abuse to the Child Protective Investigator (CPI) upon request or case closure.

Sexual abuse examination photographs are not covered under Section 39.304(1)(a) F.S. - Photographs of sexual abuse trauma shall be made part of the CPT electronic medical record and not released to the CPI, law enforcement, or the state attorney. Upon request by a CPI, law enforcement or state attorney, the CPT examiner will be available to meet with the requesting party and will make available for review the original sexual abuse examination photographs, as well as provide interpretation of the exam photos, and when necessary provide expert testimony. Copies of sexual abuse photographs should be provided only when a court order is issued.

The following documentation must be on each photograph:

Client identifier(s) – e.g., initials, DOB, case number
Date photograph was taken
Photographer's name

Storage/Child Image Management

All photographs taken of a child are considered confidential and fall under the same policies regarding the medical records storage indicated below. When situations arise which cause for the documentation of injuries (physical or sexual), photographs will be taken with appropriate digital cameras and images stored in a secure DOH drive. At no time will images be taken, stored or sent on non DOH approved equipment or non DOH Network. Providers will insure that they follow HIPPA guidelines at all time.

Recordings (Audio, Video, DVD)

Any Child Protection Team that utilizes audio, video, or DVD recording of an interview of a child who is the subject of a report must ensure that proper identification of the following is provided on the audio, videotape, or DVD:

- Date of the recording
- Who was interviewed
- Who completed the interview (name, title, agency)

3.12 Record Management and Report Confidentiality

Pursuant to s. 39.202 (6), F.S., all records and reports of the Child Protection Teams are confidential and exempt from the provisions of s. 119.07(1), F.S., the Florida Public Records Law, and s. 456.057, F.S., regarding ownership and control of patient records. Team records shall not be disclosed, except, upon request, to the state attorney, law enforcement, DOH, and other necessary professionals, in furtherance of the treatment or additional evaluative needs of the child, by order of the court, or to health plan payers, limited to that information used for insurance reimbursement purposes. Providers are responsible for having an Agency Board approved written policy in place related to public access, which addresses the type of records which must be produced or are exempt under Section 119, F.S. or procedures setting forth how requests are to be made, charges for copying documents, time-frames for providing documentation, or procedures for denying access to documentation.

Child Protection Team records reside with the contracted provider and shall be maintained according to Florida Department of Health guidelines. Providers operate under the authority of the Florida Department of Health through a standard operating contract. The Florida Department of Health shall have access at all times to any information or records generated as a result of program operation. Records shall be made available in photocopy or electronic means upon request to authorized representatives of the Department for quality improvement activities or any other audit requirements. In any instance where a CPT contract provider ceases to hold an active CPT contract with the Department, the provider shall make arrangements with the representatives of the Department for the transfer of all physical records to the newly designated contract provider or the Department as deemed appropriate by the Department.

CPTs may also share information with DCF contract providers who perform section 39 protective investigation and protective supervision services. DCF has specific legislative authority to contract for Section 39 services, which includes protective investigations and protective services; ss 39.001 (2), 39.3065, and 409.1671, Florida Statute. These providers may be considered agents of DCF, at least for purposes of performing DCF responsibilities under Section 39, and be provided copies of appropriate CPT records for the purpose of fulfilling their job responsibilities.

Computers with access to the DOH Network and CPTIS electronic case records should be maintained in a secure setting with only those individuals approved by the program office to have authorized access. All computers with DOH access will have DOH email encryption. Remaining physical records are to be maintained in locked file cabinets or drawers, and behind locked doors. All Teams should give consideration to maintaining critical program and client records in fire/weather resistant filing cabinets in locked settings. Electronic and physical case records should be secured when a staff member leaves the office. At no time should case records or any material with client identifier information (i.e... calendars with appointments, sign-in sheets, etc.) be left on a desk, in an office, or in a public access area.

3.13 Retention of Records

Administrative records pertinent to the contract must be retained per contract requirements pursuant to Section I, D., Audits, Records and Records Retention of the DOH Standard Contract. If an audit has been initiated and audit findings have not been resolved at the end of the specified retention period, the records shall be retained until resolution of the audit findings or any litigation that may be based on the terms of this contract.

All client records are considered medical records and must be retained for a minimum of seven years after the last entry was made, or until the child attains eighteen (18) years of age; whichever comes first. Each team is responsible for destruction of its physical case files based on the criteria listed above. If the team requires assistance in identifying these clients, a request must be made to the Child Protection Team Information System Help Desk. Once the team has destroyed the records, it should be documented in CPTIS; however CPTIS registrations and other case information must not be deleted.

3.14 Team Logs

Certain logs and reports may be used by the teams for tracking information other than what is gathered in CPTIS. All team logs generated on CPT clients must adhere to the statutory and handbook confidentiality requirements for CPT records.

CHAPTER 4: CHILD PROTECTION TEAM SERVICES

4.1 Assessment Process

The medically led, multidisciplinary team assessment process is instrumental in assessing maltreatments and risk in reports of suspected child abuse, abandonment, and neglect. The assessment process is focused on determining whether or not a child has been abused or neglected, identifying the immediate safety and risk factors in a case, assessing the probability of future abuse or neglect and assisting in case planning. By completing the final risk assessment, appropriate and effective interventions are recommended to reduce the level of risk and provide safety for children.

A. Determining Assessment Activities

Upon acceptance of a referral, a case coordinator is assigned to coordinate the team assessment activities and provide coordination with the CPI throughout the investigation. The case coordinator, together with the referring CPI, evaluates the extent of assessment activities that are necessary and appropriate. Unless extenuating circumstances exist, initial referrals for assessment services made late in the investigation may be determined inappropriate. See paragraph 3.4.C. (2) regarding late referrals.

Referrals from the CBC case manager may be accepted for assessment services to assist in appropriate case planning for the child and family, and should not be considered “late referrals”. Acceptance of these referrals is not mandatory, however should be provided when beneficial.

B. Team Approach to Assessment.

A multidisciplinary team approach is used to assess each child. The assessment addresses the abuse allegations and the identification of risk and interventions for reducing the risk of further abuse or neglect. All assessments should be based upon the review of existing information presented to the team from multiple sources and any new information generated by the team’s assessment activities. The CPT case coordinator should make every effort to gather independent information from all principle family members and, if possible, the child. Child Protection Team assessments should clearly indicate what information is summarized from that made available by the referral source or existing reports, and what has been obtained from interviews with the victim, involved family members, and other collaterals.

C. Types of Assessment Activities Available

Team assessment activities include, but are not limited to those listed in s. 39.303, F.S. These activities include medical diagnosis and evaluation, medical consultation, nursing assessment, specialized interviews, forensic interviews of children, social assessments, psychological evaluation and consultation, and CPT staffing.

D. Findings

If, as a result of completing assessment activities, there are findings that support the allegations of abuse or neglect, the CPI or his/her supervisor must be verbally notified within 24 hours from the date of the findings. Findings included in written reports must be submitted to the CPI or CBC case manager within the previously stated timeframes, however all written reports with

positive findings should be provided upon request for court hearings or when otherwise needed to ensure the safety of a child.

Each team shall be responsible for establishing a local protocol with the Department of Children and Families or local Sheriff's Office responsible for child abuse investigations, which will ensure proper and timely notification.

E. Conflict Resolution

If consensus regarding the need for a CPT assessment, or the outcome of an assessment cannot be reached, the team coordinator should contact the CPI's supervisor to discuss the issue. Each Child Protection Team must work with their local child protection agency to develop a local protocol for achieving consensus, including representation from appropriate legal staff, and follow this procedure in disputed cases. If the issue cannot be resolved at the local level, the team coordinator should contact their program office liaison for assistance.

If the case coordinator learns that the CPI is closing the case prior to receipt of CPT reports and there are child safety concerns the CPT Team Coordinator should be consulted to determine if the CPI Supervisor should be contacted.

F. Intake/Referral Assessment

The Intake report is to be completed at a minimum on all mandatory reports referred to the Child Protection Team, either for assessment services or for an exemption to the mandatory medical face to face evaluation. If it is determined that CPT assessment services are not appropriate on a mandatory report, the CPT Medical Director must review and concur with the decision. The Intake/Referral will be documented in CPTIS. The Intake report will be made available, either in a printed or electronic version to the CPI.

G. Interim Case Summary

If a case remains open 20 days or more following the receipt of the referral, a written status report called the Interim Case Summary (ICS) can be generated in CPTIS and provided to the CPI on the 20th day following the day of referral. The ICS report is not a mandatory requirement; however, can be utilized if the case coordinator wants to provide case status information to the CPI, especially if additional assessments are pending. Certain information will auto populate once you create the ICS report. That information consists of the abuse report number, referred child's name and date of birth, referral date, referral source and the initial reason for referral (which auto populates from the Intake/Referral Screen). Additional information populating is the list of assessments provided. The case coordinator will need to identify any pending CPT assessments and a preliminary assessment of risk factors. The team coordinator or clinical supervisor must review the ICS report in CPTIS and document their review.

If the CPT case coordinator verbally notifies the CPI of the case status, they should make attempts to determine whether the CPI case will remain open pending receipt of the assessment reports and CPT final case summary, and document the outcome. If preliminary case closure is cause for child safety concerns, the CPT Team Coordinator should be consulted to determine if the CPI Supervisor should be contacted.

H. Final Case Summary

When the team assessment activities for a child are complete, the Final Case Summary must be provided to the assigned CPI or CBC case manager. The Final Case Summary is a computer generated formal written document that provides pertinent information regarding specific assessment activities provided in each case referred to the Child Protection Team. This CPTIS generated report will have auto populated fields that include the abuse report number, referred child's name, date of birth and client ID, reason for referral (from the Intake/Referral Screen) and referral source. Additional information is the list of the assessments provided and the date each individual assessment report was sent to the CPI, or notice that the report is pending.

Each final case summary must include an assessment of risk. Issues such as domestic violence, substance and alcohol abuse, prior criminal or child abuse history, or the presence of a paramour in the home can present significant risk of serious child abuse injuries as well as child deaths. If these issues have been identified, the Final Case Summary should both identify the factor(s) and discuss how they impact family functioning and potential risk. Concurrently, issues associated with past risk factors that have been ameliorated, may be noted but should not be identified as current risk factors (e.g. a risk factor associated with an adult who is no longer in the home or associated with the family.) The goal is a synthesis of case information to provide a family specific assessment of risk. This is the team's opportunity to offer an overview of the family functioning based on information available and to assist the CPI in ascertaining both the validity of the current alleged maltreatment and the likelihood of re-abuse, or to assist the CBC case manager in case planning. An important consideration in the assessment of risk is an analysis of all prior DCF/SO and CPT involvement and how the priors impact the current situation. The goal is a synthesis of case information to provide a family specific assessment of risk.

The conclusion section should include the rationale for any findings as well as the overall CPT assessment and identify the type(s) of intervention services, if any, which are deemed appropriate.

The final case summary should be completed and provided to the CPI or CBC Case Manager following the completion of all assessment activities. Since the final case summary must be completed in order for the case to be "closed" in CPTIS, and records all final conclusions and recommendations, the final case summary should be provided to the CPI no later than 30 days following the completion of all assessments and reports.

4.2 Assessment Activities

Each assessment should be tailored to the specific child and family. Assessment activities in cases may range from a one-time consultation (medical/legal/psychological only) to the provision of a variety and number of multidisciplinary team assessment activities. Assessment activities include:

A. Intake/Referral Assessment

At a minimum, the Intake/Referral Screen will be completed on all mandatory reports referred to the team. If, through discussion, it is determined that CPT assessment services are not necessary, the Intake/Referral report is the final report. Please note that the Intake/Referral

Screen must be completed on all referrals accepted for CPT services in order for a registration to be created in CPTIS.

In order to reach the referral decision, it is important that the following be thoroughly discussed and documented:

- The demographic information of the victim and family
- Identified Issues with any family member
- Reason for Referral: Includes the allegations, information the CPI obtained during their initial assessment/contact with subjects.
- The alleged maltreatments and types identified in the Hotline report
- Discussion of prior DCF reports and CPT referrals
- Assessment Services to be provided.
- Intake/Referral Decision – Includes all documentation which supports the decision to provide services or not to provide services. If it is determined that services are not warranted, the Intake will be reviewed and closed.

B. Medical Evaluation

Medical diagnosis and evaluation includes obtaining a medical history and conducting a physical examination that could include x-ray, lab or other diagnostic procedures, performed by a CPT physician, an ARNP or Physician Assistant, when a physical examination of a child is needed to assess allegations of abuse or neglect.

Determining acuity and setting the medical evaluation.

While the mandatory nature of referrals and follow-up after screening have resulted in an increase in the number of children requiring medical evaluations, determining the setting for the evaluation and the acuity of the evaluation is based on medical judgment. In every instance, accurate triage depends on accurate information; making close communication among the case coordinator, the CPI, and the medical provider critical. Each case must be evaluated individually, however suggested guidelines include:

Hospitalized patients, acute sexual assault with penetration, and patients being seen in a medical facility for injuries thought to be secondary to abuse take first priority. Injuries that are life threatening or allegations of acute sexual abuse with penetration must be evaluated on an immediate basis unless the CPT examiner is convinced, after contact with the treating physician, that the evaluation needs of the patient have been met. The definition of immediate takes into consideration such factors as the safety of the child, the threat to life, evidence collection requirements, and other special considerations such as imminent arrest or the possibility of the family absconding. Special attention to the evaluation of children residing in the same environment must be given. If there is any reason to suspect that other children have been abused in the same setting, this information must be called into the HOTLINE (1-800-96ABUSE) and the assigned CPI notified.

Urgent evaluations may be indicated in children with some head and/or torso injuries, children whose age makes injuries suspect, children whose injuries make returning to their environment of origin potentially dangerous, alleged sexual abuse in which there are evidence collection issues, and similar cases.

Scheduled evaluations for those children determined to already be in a safe environment are indicated in the following circumstances: sexual abuse alleged to have occurred in the past, sexual abuse in which there is no allegation of penetration, and/or bruises in locations more typical for accidental injuries. Teams might consider the development of clinics where patients with minor injuries and screening of non-urgent referrals can be evaluated in a very short time with documentation and referral if needed.

The medical provider shall provide, or facilitate provision of, adequate follow-up and prevention services consistent with good medical practice.

Telemedicine: Real-time telemedicine networks for the evaluation of children suspected to be abused or neglected have been implemented in remote or rural areas. This allows for the performance of child assessments (specifically medical evaluations) via electronic communication and information technologies between Main (hub) and Satellite (remote) sites. Only CPT physicians/physician extenders (Advanced Registered Nurse Practitioners or Physician Assistants) approved as CMS medical providers and are specifically trained to do telemedicine exams can perform these exams at the hub site. Only registered nurses (RNs) specifically trained to assist with telemedicine exams can participate in the CPT medical exam at the remote site. All persons at the remote site will act under the direct supervision of the telemedicine physician or physician extender.

Documenting Medical findings.

In all cases where a medical evaluation has been completed, a clear statement of findings and conclusions must be documented in the medical report. The medical report must be available in CPTIS, either as a stored document or, once developed, on the medical report template and provided to the CPI as soon as completed, but no later than within 10 working days following the date of the evaluation.

In cases where the initial medical evaluation results in findings of no indication of abuse or neglect, the initial written medical report, which may be provided in a legally sufficient checklist format, may serve as the final medical report submitted to the CPI. This information can also be provided, as appropriate, to law enforcement personnel, or state attorney's office.

Medical assessments often require the provision and interpretation of lab work, x-rays, and other related services and photographs to document a child's injuries or condition. These reports/photographs become part of the child's record along with the CPT physician's, ARNP's or Physician Assistant's written medical report. If additional information about the same allegation or injury is received after the written medical report has been provided, an addendum report should be provided to the referral source. This does not result in an additional medical evaluation or medical consult in CPTIS. Additional medical evaluations or consults related to new allegations can be provided and counted in CPTIS provided all the Handbook requirements are met.

STD Prophylactic Medication

The provision of prophylactic medications to be used in the prevention of STD for sexual assault in adolescents and pre-pubertal children referred to the Child Protection Team for medical evaluation is part of the assessment and overall treatment provided by the CPT. Medical providers who wish to participate in this program must comply with Appendix F of this

handbook. Teams and medical providers who participate in this program are required to enter STD data in CPTIS.

C. Medical Consultation

Medical consultation is provided to render a medical opinion regarding abuse/neglect on a child(ren) that already has been evaluated by a non-CPT medical provider. Medical consultation involves situations where the CPI (or court) requests CPT to assist with a medical opinion. Consultation should not be a substitute for a CPT medical examination when appropriate, nor does it exclude the need for other CPT assessments. A medical consultation must result in a prepared report that references all the pertinent history, examination findings and laboratory/imaging studies used to reach the medical conclusions. The CPT medical record must include copies of the relevant records and reports used to arrive at the medical opinion. Consultations must be formally documented in the established team format and a report provided to the CPI upon completion, but no later than 10 working days following the consultation (receipt of all pertinent medical records). According to 39.304(3), the team may obtain records from facilities likened under Florida section 395 (hospitals); however requested records are limited to those records that involve investigation or assessment of cases of abuse, neglect or exploitation of children only. The CPI is responsible for obtaining other medical records needed for review. Receipt of the medical records must be documented. Medical consultations are appropriate, but not limited to the following situations:

- failure-to-thrive
- medical neglect
- Munchausen's Syndrome by Proxy
- history of old injuries
- cases involving fracture(s) or other serious injury where the child has left the acute care setting
- medical condition vs. maltreatment
- drug endangered children, with no other allegations of physical or sexual abuse.

In all cases where a CPT physician, ARNP or Physician Assistant has an existing medical practitioner/patient relationship with a child or his parents, the perception of a conflict of interest exists if that physician or ARNP also acts as the medical evaluator of record for the Child Protection Team.

Medical Second Opinions

It is the intent of CPT to be accurate and informative when issuing opinions about impressions and recommendations. However as with any medical opinion, there will be occasions when a non-CPT party may request another opinion. This may arise in various circumstances including: when there is a disagreement with the CPT response, or sometimes when a non-CPT physician has stated a different opinion and a community partner desires clarification/resolution. Therefore the following procedures will apply:

I. Request by community partner authorized to receive CPT reports and who is involved in investigation or prosecution of the case (i.e. DC F, Law Enforcement, Children's Legal Services, and State Attorney's Office)

- Request should be made to the team Medical Director in writing asking for:
 1. The Medical Director's 2nd opinion in reference to a medical provider opinion.
 2. An opinion by the Statewide Medical Director if that does not resolve the concern.
 3. An opinion by the Statewide Medical Director if the original concern is in reference to the opinion of the Medical director.
- The purpose is to solicit the Medical director's opinion first, and the Statewide Medical Director's opinion only if this is not sufficient.
- All pertinent records should be forwarded to the Medical Director for review.
- If the review is by the Statewide Medical director, all pertinent records should be forwarded through the Medical Director's CPT.

II. Request by non-authorized party

- If a request for another medical opinion is asked of the Medical director, this will be considered on an individual basis.
- While a response should be made, a formal opinion is not necessary and may be a violation of confidentiality, depending upon circumstances.
- If the request comes to the Statewide Medical Director it will be referred to the Medical Director, or discussed with the Medical Director if the Medical Director gave the opinion that is questioned.

III. Response

- A for mal written response will be made to a valid request.
 1. If the opinion is requested of the Medical Director, this report will be sent to the authorized party.
 2. If the opinion is requested of the Statewide Medical Director, this report will be sent to the authorized party and a copy to the Medical Director.
- If the opinion of the Statewide Medical Director is operationally challenged, an additional CPT opinion will not be issued. Appropriate action with the requesting party's agency will be taken.

D. Nursing Assessment

A nursing assessment is an evaluation of a child, performed by a licensed registered nurse, which includes an evaluation of the child's overall health, medical history, and developmental status. The nursing assessment results are entered into the CPTIS Nursing Assessment template. The report must be provided to the CPI upon completion, but no later than 10 working days following the assessment. A nursing assessment must be completed with a telemedicine evaluation will be counted as a separate assessment.

E. Social Assessment

A social assessment is an evaluation of the history of the child and the child's family system, conducted by a case coordinator or other trained professional. This involves a systematic process of gathering information from which professional impressions and recommendations regarding issues of possible child maltreatment are formulated.

The social assessment includes separate interviews of all the key members of the immediate family unless specific reasons are documented for why these could not occur, and may include interviews of extended family members or others who directly impact family dynamics. Emphasis is placed on the child and family's history, as a context for the presenting abuse or neglect allegations. Family dynamics, protective capacity of the caretakers, identifying risk factors and child safety all assist in assessing the allegations and evaluating all information to reach conclusions regarding risk and make recommendations that address the needs of the child and family.

The results of the assessment must be documented in the CPTIS report template and provided to the CPI or CBC case manager upon completion, but no later than within 20 working days following the assessment (completion of the last interview). This report may be used to assist in case planning and legal decision making. The social assessment report consists of narrative sections which provide the following:

- History of Presenting Problems – This section provides a narrative account of the maltreatments in the abuse report, information the CPI has obtained during the course of the investigation, as well as any information the case coordinator may have obtained from other sources. This section also will document the need for the social assessment.
- Family History – This section consists of descriptions of personal history for each parent/caretaker or other family members, prior agency interventions, medical history of family members and any developmental/disability issues.
- Family Functioning – This section will include family dynamics, factors that may contribute to risk, areas of dysfunction (financial, marital, substance misuse, and lack of family support, to name a few). Identification of family strengths, stability and willingness to accept assistance should also be documented here.
- Safety, Risk and Protective Capacity – This section will provide information on the parent/caretaker's protective capacities and strengths as well as any factors that effect child safety and risk.

- Impressions – This section documents impressions reached based on gathered information. Impressions should relate to identified safety or risk issues for child, and the parent/caretaker's ability to take steps to remedy the situation, address any pertinent issues and protection of the children.
- Recommendations – These are specific actions identified to address treatment plans to deal with risk factors (as they pertain to the parent's ability to protect the child), therapy needs, skill training, or the need for further evaluations (e.g., psychological evaluation). They may also address issues related to removal, placement and family supervision. These assist the family in working towards problem resolution as well as ensuring child safety in the process. Recommendations can be individual or agency specific and must be supported by documentation in the report.

F. Specialized Interviews

A specialized interview is an interview with a child or a member of the child's family, is information gathering in nature, and includes sufficient information to assist with the assessment of alleged child maltreatment, present an overview of the family history, functioning and dynamics, the development of a risk assessment, and impressions and recommendations. The specialized interview can be a stand alone interview or be included as part of a family social assessment. Their primary focus is not for legal purposes; however, they may be used in dependency or criminal cases as determined by Child Legal Services or State Attorney's offices.

Specialized interviews of children and others often serve as the key component in the assessment process. Without evidence of physical injuries or other witnesses to the abuse, the interview may be the only way to establish reliable, detailed information. Following the provision of a specialized interview the case coordinator must document the interview in CPTIS and provide the interview report to the CPI or CBC case manager upon completion, but no later than 10 working days following the interview. The specialized interview report consists of narrative sections which provide the following:

- Purpose of interview – this section clearly identifies the Hotline allegations and related referral information in the report. A summary of the information the CPI obtained should be included as well as any discussion regarding the need/reason for the interview and any risk or safety issues to be assessed based on the preliminary information.
- Summary of interview – This section should include the exploration of the Hotline allegations as well as gathering information on the family history, family dynamics and functioning. Please note that allegation specific interviews do not meet the CPT Handbook requirements.
- Safety, Risk and Protective Capacity – this section includes an exploration of child safety and risk based on information gathered in the interviews. Protective capacities and strengths should also be explored as well as overall family functioning. Consideration of prior reports/agency involvement should also be explored.
- Impressions and Recommendations – This section will document impressions reached based on gathered information. They should relate to identified safety or risk factors present for children, and the parent/caretakers ability to take steps to remedy the situation. Recommendations are actions identified to assist the family in working towards problem resolution as well as ensuring child safety in the process.

Recommendations can be agency or individual specific but must be supported by documentation in the interview report.

G. Forensic Interviews

A forensic interview is a structured interview to elicit a complete and accurate narrative of facts from the alleged child or adolescent victim in a manner that is legally sound, neutral, and fact finding in nature, to determine whether the child or adolescent has been abused (or is at imminent risk of abuse) and, if so, by whom.

Forensic interviews are conducted by a qualified CPT interviewer. A forensic interview is conducted with the alleged victim child only, while a specialized interview may extend to family members or other parties in a child abuse investigation. Case identifier fields will auto populate to the created report. The forensic interview report consists of narrative sections which provide the following:

- Purpose of interview – This section clearly identifies and explores the Hotline allegations and related referral information in the report. Summary of information obtained from the CPI and/or others (law enforcement, case managers, psychologists, therapist, medical professionals, etc.) should be included as well as the discussion regarding the need/reason for the interview. History of presenting problems should be included.
- Summary of Interview – This section should include a clear statement of events, as told by the child/victim. Any developmental issues or problems should be noted in this section. Also the CPT handbook standards, which relate to children under 4 being interviewed, should be met in this section.
- Safety and Risk Factors – This section should document any child safety or risk factors identified as a result of gathering the interview information. It is important to note any immediate child safety issues here.
- Interview Findings – This narrative section will document the findings related to the information obtained from the child's interview regarding any maltreatment.
- Recommendations – This section should document specific recommendations as a result of the findings and/or any child safety issues.

While there are no established guidelines that set specific ages for determination of the appropriateness for interviewing children forensically, there are research studies that suggest that children under the age of 4 are at higher susceptibility for suggestibility and memory issues than older children. Decisions to interview children under the age of 4 should be based on a sound and thorough developmental assessment; however, at no point should a child under 3 ½ years old be interviewed forensically.

Teams may interview children under 4 years old and include it as a specialized interview or as part of a psychosocial assessment, provided there is documentation of the child's cognitive, language and attention limitations.

A forensic interview may be recorded (audio/video/DVD). All forensic interviews will be documented in CPTIS and provided to the CPI upon completion, but no later than within 10 working days following the interview. Ear pieces may not be used during forensic interviews, unless the supervising observer is a member of the Child Protection Team monitoring the interview for quality improvement or supervisory purposes. Forensic interview information may be included in a psychosocial assessment; however the forensic interview report is not exempt from the timeline requirements.

All CPT staff that conduct interviews or supervise staffs who conduct interviews are required to complete interview training.

H. Psychological Evaluations

The Child Protection Team may recommend a psychological evaluation of a child or family member in order to provide a comprehensive assessment of an individual's emotional, behavioral, psychological, or intellectual functioning. The psychological evaluation must be performed by, or supervised by, a licensed psychologist. These evaluations are particularly helpful in identifying the short and long-term psychological effects of abuse, identifying factors that predispose families to the abuse or neglect of children, and in identifying and determining the appropriate mental health needs and interventions.

Psychological tests administered for the evaluation must meet the Frye Criteria for expert testimony in court such that the administered tests are considered to represent the best standards of practice as documented in the scientific literature. The psychological evaluations may include assessment of:

- The mental status of the child or adult
- The acute and chronic effects of abuse on children and adults
- The influences of family dynamics on the individual
- Issues of childhood development
- Parental care-taking abilities
- Mental health disorders and personality disorders
- Intellectual functions

The psychological evaluation must result in a report that provides:

- A summary of background information and present allegations
- A summary of mental status and behavioral observations
- Findings of psychometric testing and clinical interviews
- Conclusions and recommendations that may involve issues of ongoing child endangerment, child placement, treatment, risk factors, and need for further evaluation or treatment.

The report must be stored in CPTIS and provided to the CPI or CBC case manager upon completion, but no later than 20 working days following the evaluation (last interview date).

I. Psychological Consultation

A psychological consultation is the rendering of a psychological opinion by a CPT psychologist. Psychological consultation may include a review of existing records and must result in a report

that is stored in CPTIS and provided to the referral source upon completion, but no later than 20 working days following the consultation. At a minimum the report should include reason for the consultation, records reviewed and the resulting opinion provided by the psychologist to the team.

J. Developmental Screening

The Child Abuse Prevention and Treatment Act (CAPTA) of 2003 specifies that a child under age three with a substantiated case of abuse or neglect must have access to early intervention under the Individuals with Disabilities Education (IDEA), Part C. Early Steps (ES), a CMS program, is the state's leading agency for early intervention services provided under IDEA Part C, a federal entitlement program. In Florida, Part C services are administered by Early Steps. In addition, the federal individuals with Disabilities Education Improvement Act of 2004 contains requirements regarding the referral of children to Part C who are under the age of three and involved in a substantiated case of abuse or neglect or affected by illegal substance abuse or withdrawal symptoms from prenatal drug exposure, 20 U.S.C., Sec. 1437 (a)(6)(A) and (B).

The CPT and ES program entered into an intradepartmental agreement (Appendix E) which states that children under age three who are involved in substantiated cases of child abuse or neglect; affected by substance abuse or withdrawal symptoms from prenatal drug exposure; and are potentially eligible for early intervention services will have a developmental screening conducted by the local CPT and, if meet referral criteria, will be referred to the local ES provider. Each local CPT will enter into an agreement with the local ES program that will define the local referral process and responsibilities of each program.

All children seen by the CPT, who are under the age of three, will be screened for developmental delays. Exceptions to the screening are when the only assessment activity provided is a medical consultation and there is insufficient information to complete the checklist or the child is an active client with the local Early Steps program. The developmental screening will be completed by the CPT medical provider or case coordinator and stored in CPTIS. If the screening indicates developmental delays, the child will be referred to the local Early Step office utilizing the referral process defined in the agreement between the local CPT and local ES. When the referral is made, a copy of the ES referral checklist and form will be provided to the local ES program. Additionally, this will be documented on the registration screen and the case progress notes in CPTIS.

The Ages and Stages Questionnaire or another appropriate screening tool is recommended to complete the developmental screening. However, at a minimum, CPT staff will utilize the Early Steps Referral Checklist (Appendix D) for the developmental screenings. The checklist is divided into three sections. Section 1 lists the conditions that automatically qualify the child for a referral to the local ES. Section 2 contains the typical developmental milestones for children. If the developmental screening indicated the child has not obtained the milestones then a referral to the local ES should be completed. Section 3 contains other concerns that could justify a referral to the local ES program.

K. Legal Consultation

Legal consultation refers to a consultation regarding a Child Protection Team case with one or more attorneys. A consultation is generally a one-time activity, but it may include several contacts. The consultation should result in a written report that identifies reason for the

consultation, information reviewed or shared, and the resulting legal opinion. Release and dissemination of this information should be handled by the CPT attorney.

4.3 Staffings

Teams may assist CPIs and CBC case managers by facilitating or attending multi-disciplinary staffings. Information presented and shared during reviews and staffings is confidential and participants must be informed of the required CPT confidentiality. CPT Staffings are considered a core CPT service. CPT staff convene and lead staffings. Types of staffings include:

A. Child Protection Team Staffing

A Child Protection Team staffing is a meeting scheduled and led by the Child Protection Team, which may include, but is not limited to, representatives from medical, psychological or mental health (i.e., psychologist, licensed mental health counselor, LCSW, LMFT), legal (CPT attorney, GAL attorney, CWLS, SA), social worker or case manager, a representative from DCF or sheriff's office (preferably the CPI), and/or the designated community-based care provider who has primary responsibility for the case, and other professionals who have interacted with the child and family (i.e. local CMS Office, Early Steps Program and school personnel). Participants in the staffing will be determined by the needs of the child.

A Child Protection Team staffing may be convened by the team for the purposes of gathering information; or may be requested by the CPI or any other professional working with a specific family who has been referred to the child protection team for assessment services and should be scheduled and arranged as timely as possible by the CPT case coordinator. The team coordinator or their designee will facilitate the staffing.

The purpose of a Child Protection Team staffing is to assess the alleged maltreatments, safety and risk, family strengths and needs, and to develop recommendations.

Suggested cases that would benefit from a CPT staffing are as follows:

- Children who have three or more prior reports, regardless of findings, and the report meets the mandatory criteria for referral to the Child Protection Team.
- cases in which there is concern about placement and safety,
- cases in which there are legal issues needing clarification prior to dependency or criminal court,
- cases in which professionals involved do not agree,
- any complex or high risk cases in which a multidisciplinary approach is needed for comprehensive case collaboration and intervention planning, and
- medically complex children

Case coordinators must document the date of the staffing in the CPTIS case progress notes and create the CPTIS electronic report. The report will be provided to the CPI or CBC case manager upon completion but not more than 10 working days following the staffing. The report consists of the following narrative sections:

- Purpose of Staffing - This section clearly identifies and explores the Hotline allegations and related referral information. Documentation in this section should indicate the need for the staffing.

- Summary of Discussion – This section includes a summary of actions that have already occurred on the current case and any history of prior involvement with DCF/CPT or other community partners, as shared by all involved in the staffing.
- Safety, Risk and Protective Capacity - Documentation in this section should clearly indicate all identified child safety and risk factors with supporting documentation. This includes parent/caretaker protective capacity as well as identification of any barriers to the services and supports needed.
- Summary of Services and Supports Needed - Services and supports needed to address issues which impact on child safety and risk, as identified by the group.

Case identifier fields will auto populate once the report is created. These fields include the FSFN number, CPT Office, Child/victim name, DOB and client ID. Additionally, family members will auto populate from the Intake/Referral Screen. Case coordinators will utilize the remaining text fields, as indicated above, to ensure that family history, prior reports/services (and outcomes), family dynamics, child safety and risk as well as recommendations for additional case activities or interventions.

B. Staffing Attendance

Child Protection Teams may receive requests to attend a variety of meetings convened and led by other providers or agency representatives. These staffings are formal meetings of two or more separate service providers or agency representatives for the purpose of sharing information, to determine present risk to a child, making plans to complete additional assessment activities, or obtaining more information, if needed. An example would be an Early Service Intervention (ESI) Staffing. Staffings initiated by other than the team are included in this category if the purpose of the staffing includes assessment or risk issues and meets the above criteria.

Staffings attended by a member of the Child Protection Team must be documented in the electronic case progress notes indicating the date and time of the staffing, who attended on behalf of the team and summary of the staffing. The team is not responsible for completing the staffing report, however should ask who will be responsible for the completion of this report at the time of the staffing and document it in the CPT case progress record. If the staffing results in recommendations to be completed by the CPT, the team must ensure that this is clearly stated in the Intake/Referral (if no other referral has been made). If a report is not received, the team must document their request for a copy of the report and include a narrative summary of the staffing and any CPT recommendations resulting from the staffing in their final case summary.

Teams should document this assessment activity in CPTIS only when the team has accepted the referral and provided other CPT assessment services.

4.4 Court Activity – Testimony or Deposition

Section 39.303 (1) (e), Florida Statutes, requires Child Protection Teams to provide expert medical, psychological, and related professional testimony in court cases. Court activity only includes sworn or affirmed testimony in or out of court by a member of the Child Protection Team, and that activity includes the time spent in reviewing records and in team consultation for court preparation.

Since CPT records are confidential, information is usually only provided to those as specified in Chapter 3, Section 3.12 of this Handbook. Depositions and court testimonies in criminal and family court require court orders for members of the Child Protection Team to release records and information.

4.5 Other Child Protection Team Activities

In addition to case-specific assessment activities, CPT staff are responsible for other activities, that are not related to a case that has been opened in CPTIS. These activities include:

A. Training

Section 39.303 (1)(h), Florida Statutes, requires that Child Protection Teams provide training to physicians and other medical personnel and to other professionals, including, but not limited to DCF staff, law enforcement, school personnel and GALs, on the identification or determination of abuse or neglect. Training includes public and media presentations on child abuse as well as specific training designed to develop and maintain the professional skills and abilities of those handling child abuse, abandonment and neglect cases.

Additionally, staff are required to complete training that includes a minimum of eight hours per year in child abuse, abandonment, and neglect for appropriate Child Protection Team staff and subcontractors.

Data on physician, team and staff trainings must be entered into CPTIS. To avoid duplication of training events, the training event itself is counted as one activity if it covers the same training topic. For training events that provide multiple sessions, different topics and presenters, each session may be counted as a single event. If there are multiple presenters for one topic training, only one presenter may be identified in CPTIS and the training will be entered one time only. Also note that training a medical student over a period of time is counted as one event.

CHAPTER 5: PROGRAM STANDARDS AND QUALITY ASSURANCE

5.1 Standards Authority

The Child Protection Team program operates in accordance with the standards and program rules established in s. 39.303, F.S., and Chapter 64C-8, Florida Administrative Code. Operational procedures and standards are further clarified in this handbook and in the annual CPT contract. Program rules and standards address issues of eligibility for services, provider qualifications, services, and record/data requirements. A formal assessment of team services and compliance with program standards and requirements is conducted on a bi-annual basis through the quality assurance/improvement on-site reviews to help ensure quality in CPT programs.

5.2 Performance Standards

A. Standards

By executing the contracts, CPT providers agree to comply with the conditions, standards, and indicators of performance set forth in the contracts. These requirements include but are not limited to:

Assessment Activities. For all children appropriately referred to and accepted by the team, assessment activities will be completed within 20 calendar days following the date of referral, unless an appropriate exception is documented, 90% of the time. Achievement will be determined through a review of CPTIS statistical reports.

Abuse Report Review. All reports of abuse, neglect and abandonment received by the team shall be reviewed by the medical director and the team coordinator (or their respective designees) to determine if the report meets the mandatory criteria for referral to CPT, 100% of the time. Achievement will be determined through a review of CPTIS statistical reports.

Final Case Summary. A formal written document will be sent to the CPI or CBC case manager to provide pertinent case information at the time of case closure. Achievement will be determined through a review of CPTIS statistical reports.

Positive Findings – Verbal Notification. CPT will verbally communicate any positive indication of abuse or neglect to the CPI, or his/her superior, within 24 hours of determination, 95% of the time. Achievement will be determined through a review of CPTIS statistical reports.

Assessment Report Timeliness. Written assessment reports will be provided to the CPI or CBC case manager within the time frames, 90% of the time, and must contain all elements as specified in the CPT Handbook. Achievement will be determined through a review of CPTIS statistical reports.

Medical Training. The provision of a minimum number of training sessions for emergency room and other non-CPT medical personnel in the detection of child abuse and neglect during the contract period. Achievement will be determined through a review of CPTIS statistical reports.

Child Protection Team Training. The provision of a minimum number of training sessions for DCF, local sheriff's offices and other local agencies, involved in child protective investigations or services, in mutually agreed upon subject areas of child abuse and neglect during the contract period. Achievement will be determined through a review of CPTIS statistical reports.

Child Protection Staff Training. The provision of a minimum number of hours of training in child abuse, abandonment and neglect for appropriate Child Protection Team staff and subcontractors. Achievement will be determined through a review of CPTIS statistical reports.

The core contract for the teams identifies services that must be provided by each Child Protection Team and the required percentages for compliance with the above standards. Compliance with contract standards will be determined through CPTIS reports and team quarterly performance measure reports and, if applicable, quarterly conference calls with the contract manager. For this reason, the team coordinator and medical director must ensure that all services and activities are documented in CPTIS. On-site or desk reviews validate data in CPTIS.

B. Monitoring

Child Protection Teams must meet the core performance standards set forth in the executed contracts. By execution of the contracts, providers acknowledge an understanding that the achievement of these standards will be reviewed, achievement reported, and corrective action made when performance standards have not been met. If the department affords the provider an opportunity to achieve compliance, and the provider fails to achieve compliance within the specified time frame, the department can terminate the contract in the absence of any extenuating or mitigating circumstances. The determination of the extenuating or mitigating circumstances is the exclusive determination of the department.

1. Scope of Review

At a minimum, all quality assurance reviews must include an assessment of compliance with the standards and requirements outlined in the contract.

2. Methodology

The provider's program will be reviewed annually, unless otherwise determined by the program office, utilizing standard statewide monitoring instruments.

3. Reports

The report resulting from the review will address the team's performance in relation to minimum standards and CPT Handbook requirements. The report may include recommendations for addressing performance measures not met.

Additionally, the quarterly CPTIS Performance Measure report (emailed to providers and contract managers the 10th day of the month following the quarter) is used by the team coordinators to complete the Quarterly Compliance report which is provided to the contract

manager no later than 10 working days after the 10th day. Data from this report is used to address ongoing compliance with contractual performance standards. Appropriate follow up via a conference call, if needed, will be determined by the contract manager and team coordinator.

C. Waivers

In the event that compliance with a standard established in Chapter 64C-8, Florida Administrative Code, is not attained, a team may request a waiver of that standard. The CMS program office will make final approval or disapproval of all requests for waivers. The CMS Program Office shall notify the team in writing that the request for waiver of a specific standard has been granted or denied. All request for waiver involving personnel qualification must be submitted by the team and approved by the program office prior to hire. All requests for waivers to be submitted must follow the protocol established by the Program Office.

CHAPTER 6: CHILD PROTECTION TEAM INFORMATION SYSTEM

6.1 Child Protection Team Information System (CPTIS)

The Child Protection Team Information System has been created to meet the data needs of the local Child Protection Teams and Children's Medical Services. This includes tracking client registration, service provision, assessment reports and case progress notes as well as the ability to track program compliance with contractual requirements, and measuring program performance on key indicators. This system provides all authorized CPTIS users with the ability to follow the case from the date the case was accepted for services until the date the case was closed. Key elements of the system include on-line display or printable case-specific information, and printed management reports (individual coordinator, team and statewide) for use by both CPT and CMS staff.

CPTIS version 1.11 is a .NET web-based program supported by the CPT program office and the DOH Information Technology (IT) office. Major elements of the system are: demographic information, referral information, registration information, assessment activities and reports, family information, abuse report review, other CPT activity, and provider information. Each of these sections contains screens necessary for data input. Each screen has "mandatory" fields, i.e., fields that are required to successfully create a new record. Each screen also has built-in edit checks to ensure data integrity.

6.2 System Security

The system requires the user to enter a unique USER ID and PASSWORD. The USER ID/PASSWORD combination contains the security codes necessary for the various security profiles. The four security levels are: Administrator, Manager, User and View Only. The *Administrator* profile is limited to key program office staff. The *Manager* profile has unrestricted rights and may view, update and delete information in the system, with the exception of a demographic screen. The *User* profile has restricted rights and may add and update, but can not delete specified information. The *View Only* profile may only view records and print reports. Users and managers must not share USER IDs or PASSWORDS with anyone, including other persons who have access to the data system.

All new staff/providers/volunteers will be required to complete the DOH Security Information test in the Trak-It System prior to being given approval for access to the DOH Network and any database systems accessed through the DOH Network. Once the team coordinator has submitted the appropriate forms to the program office and access has been approved, the usernames and passwords will be sent to the individual. At no time will passwords and user names be shared or access provided by use of a staff person's username and password. Please review the CPTIS Guide for the policy and procedures related to new user access.

The CPTIS User Guide provides instructions for navigating through the data system. Please refer to the Guide for more specific explanations and instructions.

6.3 System Screens

CPTIS screens capture case specific information to create the electronic case file. Each team is responsible for ensuring that data in CPTIS is accurate and up to date. Team coordinators and

case coordinators are expected to review CPTIS case specific screens, reports and client histories for accuracy.

CPTIS data screens include:

- **Abuse Report Review** – Documents all abuse reports received from the Department of Children and Families or designated sheriffs' offices and reviewed by the team. It also documents all abuse reports identified as meeting mandatory referral criteria.
- **Intake / Referral Screen** - Captures information pertaining to child abuse investigations, client and family demographic data, alleged maltreatments identified, assessment services agreed upon and the intake/referral decision.
- **Demographic Screen** – Provides specific information on each client in the data system (name, address, age, race, etc). This screen is also used to enter family/household member information.
- **Registration Screen** – Documents initiation and termination dates, alleged and assessed maltreatments, the overall case finding, and the dates that the Interim, if completed, and Final Case Summary reports sent.
- **Assessment Activity Screen** – Tracks all assessment activities provided by the team.
- **Assessment Report Screens** – Provides specific information based on the type of assessment activity completed.
- **Case Progress Notes Screen** – Provides individual case activities completed.
- **Case Progress Notes Report** – Provides complete history of case notes completed.
- **Report Summary Screen (Interim, Final and Addendum)** – Captures information on the reason for referral, assessments provided, assessment of risk, and conclusions/recommendations in a case.
- **Other CPT Training** – Tracks contractually mandated training provided or attended by team members and appropriate subcontracts.
- **Provider Information** – Contains information regarding individuals (such as psychologists, attorneys, medical providers, case coordinators, or team coordinators) who provide team services.

6.4 CPTIS Management Reports

Management Reports – Compiles data specific information in the team or statewide format. These include but are not limited to:

- Abuse Report Review
- Performance Measure Report
- Caseload Report
- Summary of CPT Assessment Activities
- Active Cases
- CPT Training Report

Management Data Review

Early Steps Report

Additional CPTIS Menu options are:

- **Help Center** – Allows users to type in data requests, questions and concerns related to CPTIS.
- **System Guide** – This user guide will be maintained on the Children’s Medical Services website and in CPTIS. It will be updated regularly to reflect modifications to the system or changes in policy that might impact code tables or definitions.
- **Help Maintenance** – Allow the administrator of the system to update the definition of a specific field. This item will not show for any user other than administrator.
- **User Options** – Allow the user to enable/disable the pop-up calendar used in the system.

S. System Enhancements and Changes

During the course of the year, system enhancements or changes may be implemented to improve data collection or to increase system outputs. Team staff will receive email notifications of system enhancement and changes prior to the changes being moved into production. Team staff will be responsible for maintaining an updated CPTIS Guide (which will include email notifications throughout the year) to ensure accurate data input and collection.

APPENDIX A: PERSONNEL QUALIFICATIONS AND RESPONSIBILITIES

A. Statewide Medical Director

Qualifications:

- Graduation from an accredited school of medicine with board certification in pediatrics and licensed to practice in the state of Florida.
- Approved CMS physician provider (as defined in the CMS Provider Handbook- Physicians and Dentist).
- Have demonstrated interest in and received training in child abuse and neglect diagnosis, maintain direct medical skills in medical evaluations of child abuse and be willing, as directed by CMS, to continue child abuse and neglect in-service training

Responsibilities and Duties:

- Provide statewide overall medical direction and supervision of the child protection teams.
- Provide statewide leadership in establishing an effective and coordinated response to Child Abuse Hotline reports with the Department of Children and Families representatives.
- Provide, upon request, second opinion medical evaluations of children within time frames as specified in the CPT Handbook.
- Recruit, and make recommendations to the Division Director of Children's Medical Services for appointment and dismissal of team medical directors.
- Complete and provide to the CMS Division Director or designee, annual evaluations of all team medical directors within 30 days of the departments fiscal year end date.
- Coordinate with the team Medical Directors to ensure that all team medical providers have obtained CMS approved Physician or Physician Extender Status, prior to employment or execution of service contract.
- Direct and monitor child abuse education for CPT medical providers and team staff by utilizing video conferencing and webinar technology. Provide abuse and neglect training sessions for scheduled meetings.
- Participate as a committee member in the statewide Child Abuse Death Review Committee.
- Provide statewide guidance and annual review of medical directors' (or designee) screening of child abuse reports made to the Florida Abuse Hotline.
- Be available 24 hours a day, seven days a week for consultation to team members and team physicians, including telemedicine consultation, when available and appropriate, for medical assessment needs. Arrange coverage by another CMS approved CPT Medical Director when unavailable.
- Participate in monitoring of child protection teams as a member of the statewide designated monitoring team.
- Attend statewide child protection team meetings and other meetings and training sessions as required to maintain the knowledge and skills required for this position. Maintain direct medical skills in medical evaluations of child abuse.

- Provide depositions and expert court testimony when appropriate. Reimbursement for expert testimony is not provided by CMS and must be sought by the physician through the usual court procedures.
- Successful completion of a minimum of eight hours of medical training per year in child abuse, abandonment, and neglect.
- Utilize the Child Protection Team Information System to document CPT assessment activities and quarterly report activities.

A. Team Medical Director

Qualifications:

- Graduation from an accredited school of medicine with board certification/eligibility in pediatrics and licensed to practice in Florida.
- An approved CMS physician provider (as defined in the CMS Provider Handbook – Physicians and Dentists)
- Demonstrated or expressed interest in the field of child abuse and neglect and must receive training deemed necessary by the department for evaluating alleged abuse and neglect.
- Availability to provide oversight of team and client assessments.

Responsibilities and Duties:

- Provide overall direction and supervision of the team(s) for program service delivery and administration.
- Provide leadership in establishing an effective and coordinated response to Child Abuse Hotline reports with the designated area Department of Children and Families representatives. Participate and represent the team(s) in the designated community service area as appropriate.
- Provide medical evaluations of children and supervise and review the work of the provider agency's team medical practitioners, including contracted and fee for service medical personnel for the provision of team medical evaluations of children suspected to be abused or neglected.
- Recruit, and make recommendations to the Deputy Secretary for Children's Medical Services for appointment and dismissal of team physicians and other medical professionals, including fee for service or independent contract personnel for team medical services. Assist physicians and Advanced Registered Nurse Practitioners recruited in obtaining CMS approved Physician or Physician Extender Status.
- Work in collaboration with contracted agency representatives in the recruitment, appointment and dismissal of Team Coordinator or Case Coordinator positions.
- Review and sign off on the annual team budget and final revenue and expenditure report.
- Arrange for and provide in-service training and other professional development for team staff and medical personnel. Assist the statewide CPT medical director in the planning and provision of training for regional and statewide training sessions.
- Participate as a committee member (or appoint a medical designee) in the local Child Abuse Death Review Committee.

- Annually, plan and conduct a minimum of two training sessions in the detection of child abuse and neglect for area physicians and other medical staff, particularly those working in the hospital emergency rooms.
- Provide guidance and oversee the team's screening of child abuse reports made to the Florida Abuse Hotline and provide selected direct screening as required by law, or when otherwise determined appropriate.
- Be available 24 hours a day, seven days a week for consultation to team members and team physicians, including telemedicine consultation, when available and appropriate, for medical assessment needs. Arrange coverage by another CMS approved CPT Medical Director when unavailable.
- Assure medical representation for team staffings.
- Participate in peer reviews with other team physicians and other medical providers. If designated and approved, participate in monitoring of child protection teams as a member of the statewide designated monitoring team.
- Attend statewide child protection team meetings and other meetings and training sessions as required to maintain the knowledge and skills required for this position. Maintain direct medical skills in medical evaluations of child abuse.
- Provide medical consultation in an area of expertise to other teams when requested.
- Provide depositions and expert court testimony when appropriate. Reimbursement for expert testimony is not provided by CMS and must be sought by the physician through the usual court procedures.
- Successful completion of a minimum of eight hours of medical training per year in child abuse, abandonment, and neglect.
- Track the completion of training requirements for all medical providers.
- Ensure all medical providers have been approved as a CMS physician provider prior to employment.

B. Medical Provider

I. Advanced Registered Nurse Practitioner (ARNP)

Qualifications:

- Licensure in the state of Florida to practice professional nursing and certification in advanced or specialized pediatrics or family medicine nursing practice.
- Experience in the evaluation and treatment of child abuse and neglect or agree to receive training deemed necessary by the department for evaluating alleged abuse and neglect.
- CMS approved physician extender (as defined in the CMS Provider Handbook-Licensed Non-Physician Healthcare Professionals).

Responsibilities and Duties:

- Provide diagnostic evaluations and medical consultations regarding abused and neglected children.
- Attend team staffings, as necessary.
- Prepare medical reports of evaluations and medical consultations in CPTIS.
- Provide depositions and court testimony.
- Participate in after hours on call, as scheduled.

- Successful completion of a minimum of eight hours of training per year in child abuse, abandonment, and neglect.

II. Physicians

Qualifications:

- Graduation from an accredited school of medicine with board certification/eligibility in pediatrics and licensed to practice in Florida.
- An approved CMS medical provider (as defined in the CMS Provider Handbook-Physicians and Dentists).
- Experience in the evaluation and treatment of child abuse and neglect or agreement to receive training deemed necessary by the department for evaluating alleged abuse and neglect.

Responsibilities and Duties:

- Provide diagnostic evaluations and medical consultations regarding abused and neglected children.
- Attend team staffings, as necessary.
- Prepare written reports of evaluations and medical consultations.
- Provide depositions and court testimony.
- Participate in after hours on call, as scheduled.
- Successful completion of a minimum of eight hours of training per year in child abuse, abandonment, and neglect.

III. Physician Assistant (PA)

Qualifications:

- Licensure in the state of Florida to practice.
- Experience in the evaluation and treatment of child abuse and neglect or agree to receive training deemed necessary by the Department for evaluating alleged abuse and neglect.
- CMS approved physician extender (as defined in the CMS Provider Handbook-Licensed Non-Physician Healthcare Professionals).

Responsibilities and Duties:

- Provide diagnostic evaluations and medical consultations regarding abused and neglected children.
- Attend team staffings, as necessary.
- Prepare written reports of evaluations and medical consultations.
- Provide depositions and court testimony.
- Participate in after hours on call, as scheduled.
- Successful completion of a minimum of eight hours of training per year in child abuse, abandonment, and neglect.
- Maintain national certification as a physician assistant (recertifying board exams every six years).

C. Team Coordinator**Qualifications:**

- Bachelor or Masters Degree in a Human Services field, Psychology, Social Work, or Nursing.
- At least three years of post-bachelor experience in the field of child abuse and neglect, one of which must have been in program management.
- In addition to the requirements as specified in Florida Administrative rule, 64C-8.002(2)-(b), team coordinator qualifications will include at least one year of experience in Child Protection Services (Child Protective Investigations, Community Based Care Case Management, Child Protection Teams).

Responsibilities and Duties:

- Coordinate the daily activities and services of the CPT, including arranging for non-medical staff availability 24 hours a day, 7 days a week.
- Train, coordinate, and supervise team staff.
- In conjunction with the medical director, ensure that child abuse reports made to the Florida Abuse Hotline are received and that reports are reviewed by the medical director.
- Coordinate services with the child protection staff from DCF and other agencies, other health programs, and local community resources.
- Serve as a liaison with the CMS Program Office to ensure compliance with standards, policies, and performance criteria.
- Participate in the development of the team budget.
- Assist the team medical director in the overall operation of the team.
- Provide or arrange for training in the community for professional staff and others.
- Successful completion of a minimum of eight hours of training per year in child abuse, abandonment, and neglect.
- Ensure that required training hours for staff and subcontractors is documented in the Child Protection Team Information System.

Due to the level of required expertise, education and training, a waiver will not be granted for this position.

D. Case Coordinator**Qualifications:**

- A Bachelors or Masters degree in a Human Services field, Psychology, Social Work or Nursing.
- At least two years of post-bachelor experience working with children or families, one year of which must be working with abused and neglected children.

Responsibilities and Duties:

- Interview children, family members, and significant others as needed to obtain medical and psychosocial information.
- Complete assessments and send reports to the CPI upon completion, but no later than within the time frames consistent with program requirements and best practice.

- Coordinate client services and referrals to community agencies.
- Arrange for and conduct team staffings and participate in the development of the recommendations.
- Provide depositions and court testimony.
- Maintain client records.
- Conduct training in the community for professional staff and others, as designated by the team coordinator.
- Participate in scheduled after hours on call.
- Successful completion of a minimum of eight hours of training per year in child abuse, abandonment, and neglect.

E. Team Psychologist:

Qualifications. The psychologist for the Child Protection Team shall be required to meet the following standards and qualifications:

- Licensure under Section 490, Florida Statute, and will adhere to the standards of competent, ethical practices in accordance with the American Psychological Association and the Florida Department of Business and Professional Regulation (DBPR).
- Formal, specialized graduate training and successful completion of ongoing continuing educational training in the areas of child development, child and adult psychopathology, all aspects of childhood abuse and victimization, post traumatic stress disorder (PTSD), and psychotherapy with children and adults.
- A minimum of one year of supervised experience and two years minimum of independent professional experience in the evaluation of children and adults. Included in the three years of professional experience shall be at least 100 hours of experience in dealing with child abuse cases including neglect, physical abuse, sexual abuse, psychological abuse, failure to thrive, and other forms of childhood victimization.
- Should have sufficient professional experience and expertise that would allow them to be qualified as a mental health and family violence expert in criminal, civil and dependency courts in Florida.
- A CMS approved provider (as defined in the CMS Provider Handbook – Licensed Healthcare Professionals).
- Available to work with the team on a part-time or full time basis under the administrative supervision of the team medical director and/or team coordinator as appropriate.

Responsibilities and Duties. The psychologist for the CPT must play a number of essential roles for the team that involve both clinical and forensic aspects of child abuse or neglect and family violence. The psychologist will be required to provide a broad array of clinical services that will include but not necessarily be limited to:

- Psychological evaluation of children and adults in cases of alleged child abuse and neglect.
- Clinical interviews with children.
- Consultation with case coordinators in their assessments
- Referral of children and adults to psychotherapy for abuse and neglect issues.
- Timely submission of written reports of evaluations to the team as required by contract or dictated by best practice.

- Participate in team staffings and the development of recommendations.
- Provide depositions and expert court testimony when appropriate. Reimbursement for expert testimony is not provided by CMS and must be sought by the physician through the usual court procedures.

F. Team Attorney**Qualifications:**

- Member of the Florida Bar.
- Availability to work with the team on a part-time basis under the administrative supervision of the team medical director or designee.

Responsibilities and Duties:

- Provide legal services, consultation, and training to the team.
- Attend staffings as necessary and, when appropriate, participate in the development of recommendations.
- Represent the team or individual members who are acting in their official capacity as team members in court.

G. Professional Consultants (which includes physicians, ARNPs, attorneys, psychologists (or psychiatrists))**Qualifications:**

- Availability, as needed or appropriate, for consultation, diagnosis and evaluation in cases of child abuse or neglect
- Experience in the evaluation and treatment of child abuse and neglect or agreement to participate in training, as required.
- Must meet the qualifications as listed above.
- For appropriate positions, be a CMS approved provider.
- For consulting pediatricians: graduation from an accredited school of medicine with board certification/eligibility in pediatrics, licensed to practice in Florida and be an approved CMS physician.

Responsibilities and Duties:

- Provide diagnostic evaluations and medical consultations regarding abused and neglected children.
- Attend team staffings, as requested, on children for whom services were provided to assist in the development of recommendations.
- Provide written reports to the team within established time frames as specified in the contract.

Appendix B: ADMINISTRATION

Certain statewide guidelines and protocols have been developed to assist providers in complying with requirements for the delivery of program services under the Child Protection Team program (CPT contract). The Child Protection Team contract is a statewide program-specific model contract. The information in this section is specific and supplemental to the contract language. Contract language may be repeated for clarification.

A. Fiscal

1. Method of Payment.

The Child Protection Team contract method of payment is based on a negotiated fixed rate (fixed fee) total annual contract amount disbursed monthly at a fixed rate, paid after the delivery of a month's services. When there is a renegotiation of the total annual contract amount during the contract year, the remaining monthly fixed rates are adjusted accordingly.

2. Program Budget

Once contract amounts are determined, providers must submit a proposed program budget and supporting narrative to the program office. The proposed budget is the justification for funding service delivery and must have documentation that the budget was reviewed by the CPT Medical Director. The contract manager reviews the proposed program budget, resolves any questions/issues with the provider and approves prior to contract execution or approved with written contingencies and due dates that are binding on the provider. Inherent in the approval of a program budget is the provider's acknowledgement of the requirements for on-going management of the program budget throughout the contract period. The proposed program budget must project revenue and expenditures for the program services and eligible clients defined in the CPT contract.

All program income available (including any received but not expended to date) and expected to be received during the contract period must be projected, and each type identified by line item with narrative explanation.

a. Deficit Budgeting

Deficit budgeting is not allowed. However, if revenue projections exceed planned expenditures, initially and temporarily, a "contingency" expense line item may be budgeted to allow time for planning for the use of the unexpected revenue available prior to the end of the contract year.

b. Format

Providers must complete their CPT budgets utilizing the Provider Budget format (which includes the following sections: Funding, Position Detail, Proposed Expenses (DOH), 3rd Party Expenses and the Narrative that details the Proposed Expenses (DOH), which is provided by the CMS Program Office, or their agency format must have all the same information.

V

c. Proposed Expenditures

Proposed expenditures must be reasonable and necessary in order to provide the program services defined in the contract. An accompanying budget narrative must indicate the type of expenditure by line item and clearly explain how the proposed expenditure supports the program.

d. Cost Sharing

When costs are shared with other programs of the provider agency, the provider must determine the Child Protection Team share of cost based on an acceptable methodology (i.e. head count, square footage). The proposed budget narrative must specify the totals (e.g. head count) and the total cost and show the calculations to arrive at the CPT share of the cost.

Positions that show shared funding must have time study reports completed to provide justification for the time spent and cost charged to the CPT program budget.

e. Percentages of Cost

Any percentage of direct personnel salary and benefit costs for general agency management paid for by CPT funds must include clear documentation of each individual's functional activities supporting the provision of CPT services and related administrative duties. **NOTE:** The Team Coordinators and/or designees must spend a minimum total of 75% of their time providing programmatic and administrative oversight of the CPT contract program.

Indirect Cost Rate Percentage must be negotiated (except for maximum statutory rates for state agencies).

f. Travel Expense Budgeting.

The provider must budget and pay for any work related costs for travel and required training of the CPT medical director, and may pay for travel and training costs specified as needed by the CMS Program Office for other professional contractual personnel, unless such costs are included in the rate of pay agreed upon with the sub-contractor. Language in the subcontract for other professional contractual personnel must clearly state the provider's intent to pay for required travel and training, as it relates to services provided to the CPT.

The provider must budget sufficient travel expense to ensure that Child Protection Team staff attend all required meetings and trainings. If a CPT employee's financial resources are not sufficient to support required travel, the provider must consider prepayment or advance funds to accommodate the employee's participation.

All travel reimbursement must be supported by the use of travel voucher forms which identify meal allowance, per diem rates, mileage rates and date/time of departure and return. Further, the purpose of travel and benefit to the program should be clearly documented.

g. Unauthorized Expenditures

Certain types of expenditures will not be approved. These are:

- 1) Depreciation of non-expendable property, which is defined as those items costing \$1000 or more per item (or packaged item). Expenditures to acquire such property are allowed provided they are reasonable and necessary.
- 2) Depreciation of assets other than non-expendable property, including fixtures and buildings. Necessary and reasonable acquisition costs for assets and buildings may be budgeted based on the CPT share of cost. Actual current building expenses presented as rent must be evaluated as to reasonableness based on local market rates.
- 3) Food
- 4) Purchases that confer or provide ownership by clients (food, clothing, furniture, etc.) Travel costs may be paid for a client in order for them to participate in CPT services when not available otherwise.
- 5) Fund-raising and lobbying costs.
- 6) Miscellaneous line-item costs (or petty cash funds) exceeding \$150.00
- 7) Any other cost that is determined not to be reasonable and necessary to the provisions of services under the contract.

h. Special Projects Budgeting

Special projects are those services not considered a part of the basic CPT statewide assessment services. These projects must be separately identified and budgeted as a special sub-category with specific line items, including narrative explanation and justification. Any income specifically designated for the project must also be identified as a line item in the income section of the budget, including a narrative to explain all sources of income.

These projects must have separately identified program deliverables. Final expenditures and income must be reported in the same separately identified format as in the approved budget. (See also paragraph p. "Final Expenditures and Revenue Reporting").

- 1) Telemedicine Component. If a provider's CPT contract has a telemedicine support component and funds are received to support the telemedicine costs and activities, the income and budget must be separately identified in the budget process and final reporting.
- 2) Medical Oversight. For those teams that contract for medical oversight, this component is not considered a "special project", however, the deliverables must be separately identified in the contract program budget, and final expenditure and revenue report.

i. Use of Child Protection Team Funds for Matching Purposes

Federal funds cannot be used to match other federal funds. Child Protection Team funding is primarily state general revenue and federal Social Services Block Grant Funds, and most CPT contracts include both sources of funding. The federal Social

Services Block Grant Funds used by the DOH CPT program do not have any matching requirements; therefore, the CPT state general revenue is not being used to match any federal funding source.

While state funds can be used to match federal funds, because CPT state general revenue can only be used for carrying out the CPT contract program these funds can only be used to match federal funds if the use expands the CPT program to provide additional services or contract eligible clients. Additional federal funds received would become CPT program income and must be budgeted as such.

Note: The administering agency for federal funds makes the determination as to what funds are acceptable as matching funds for their particular federal program. If consideration is being given to use of the CPT program state general revenue as match, the provider must share the department's position as to their use stated in the above paragraph.

j. Program Budget Management.

Each provider must have a contract budget management team that, at a minimum, includes the CPT Medical Director, the CPT Team Coordinator and provider agency administrative and fiscal personnel. The budget management team must prepare the Child Protection Team budget, plan for the generation of revenue and review the budget, expenditures and revenue status on a periodic basis, and plan for any necessary revisions as needed.

k. Budget Revisions.

Refer to the criteria in Attachment I, Section D, of the contract. Whenever a question arises as to what is a substantive budget revision, it should be discussed with your contract manager prior to submitting a budget revision for review.

l. Program Revenue.

Providers are expected to pursue and bill all third party and other possible revenue sources for the CPT program. Program income is defined in Attachment I, Section D, of the contract.

m. Documentation. The Provider is required to maintain separate accounting of revenues and expenditures of funds under this contract and each CSFA or CFDA number identified on Exhibit 1 of the contract, in accordance with generally accepted accounting practices and procedures. Expenditures which support Provider activities not solely authorized under this contract must be allocated in accordance with applicable laws, rules and regulations, and the allocation methodology must be documented and supported by competent evidence.

Provider must maintain sufficient documentation of all expenditures incurred (e.g. invoices, canceled checks, payroll detail, bank statements, etc.) under this contract which evidences that expenditures are:

- a. allowable under the contract and applicable laws, rules and regulations;
- b. reasonable; and
- c. necessary in order for Provider to fulfill its obligations under this contract.

The aforementioned documentation is subject to review by the Department and/or the State Chief Financial Officer, and Provider will timely comply with any requests for documentation.

- n. Financial Report.** The provider must submit financial reports, as stated in Attachment I, Section D. of the contract within the required contractual time frames. The financial reports will state, by line item, all expenditures made as a direct result of services provided through the funding of this contract to the department. Each report must be accompanied by a statement signed by an individual with legal authority to bind provider certifying that these expenditures are true, accurate and directly related to this contract.
- o. Prior Approval for Purchasing -Information Resource Requests (IRRs).** Prior to purchasing data processing equipment, regardless of the cost of an item, providers are required to submit an IRR to the department for approval. This request and approval process is to ensure that: data processing equipment meets the department's standards, the CMS Program Office is aware of each team's technological capacity and needs, and verification of the provider's contract inventory of technology assets purchased with CPT funds.

Providers are required to submit an IRR and the vendor quote chosen for the item to be purchased for the following data processing equipment and software: Servers, computers, printers, software and upgrades of same; and all telemedicine equipment packages, including any telemedicine upgrades or replacement items. All items to be purchased must meet the department's current standards. The state standards and approved contract vendors are identified through DOH Intranet. Providers must follow their agency purchasing policy in determining the vendor to be used. State contract negotiated prices may be available to the provider. Note: The department strongly recommends that minority vendors be used when purchasing. IRRs must be submitted to the CMS contract manager.

When approved, the IRR will be returned to the CPT to document the purchase of the data processing equipment. A copy of the approved IRR should be attached to the purchase order and a copy placed in the current fiscal year provider contract file in the CMS Program Office.

p. Final Revenue and Expenditure Report

A final revenue and expenditure report is required to be submitted within 45 days of the end of the contract fiscal year. A statement of the medical director's review of the report must accompany the report to the program office. While final income and expenditures may vary some from the approved budget or the most recent submitted revision, any substantive difference must be explained prior to the CMS Program Office acceptance of the final report for the contract year. Special projects components must be separately identified and reported in the same format as in the approved program budget. Non-expendable property items (items costing \$1000 or more per unit) must be identified by item and unit cost.

- 1.** Based on the requirements of Federal OMB Circular A-110, which would apply to any non-profit receiving Federal Financial Assistance under a CFDA # or State

match on a Federal Program under a CFDA #, the organization has 90 days after the current state funding year (fiscal year) to pay "un-liquidated obligations" (as defined below). To be considered an unliquidated obligation, the expenditure must still have been incurred before the end of the contract period, just not yet paid. For example, if a non-profit has a delayed payment bi-weekly pay period and the contract end date falls one week into such a pay period, then that one week of salaries and benefits would be considered an unliquidated obligation and can still be charged to the contract, even though it will not be paid until after the contract has ended.

2. Unliquidated obligations, for financial reports prepared on a cash basis, means the amount of obligations incurred by the recipient that have not been paid. For reports prepared on an accrued expenditure basis, they represent the amount of obligations incurred by the recipient for which an outlay has not been recorded.

B. Independent Audits

Each CPT provider must provide the department an Independent Audit for each fiscal year. As a result of the Single Audit Act, some Independent Auditors are now completing a compliance audit requiring the auditor's review of a random sampling of CPT client records. The CMS Program Office contract manager should be contacted to request a random sample from the CPTIS database for the audit.

1. Sampling Client Records

While auditors are required to comply with federal and state laws regarding protection of confidential information, both the DOH and the DCF legal counsels have determined that auditors need to follow a specific protocol when viewing client records containing child abuse information. Therefore, there are two agreements that the Independent Auditors need to execute prior to beginning this audit. They are:

- a. DOH's "Agreement for Independent Audit Protocol" and
- b. DCF's "Privacy and Security" agreement.

Each audit year, these agreements, pre-signed by each department's representative, are to be signed and dated by the Independent Auditor representative and sent to the contract manager, prior to the CMS Program Office pulling a random sample.

2. Protocol for Audit of Child Protection Team client records.

a. Team

The CMS Program Office sends the sample list of children's records to be reviewed to the team. This list provides the information the team needs to locate the records. A team representative is to pull the closed records and be present during the auditor's review. If the auditor needs to review an abuse report, the reporter's name must first be redacted by the team before sharing the report. The children's records must not be copied.

b. Auditor

The auditor's sample contains the Abuse Report #s and termination date when received from the CMS Program Office. The auditor is instructed that a team

representative will pull the records and remain in the room while the records are reviewed. No copies of information are given to the auditor.

3. Audit Report and Corrective Action

Audit reports are due 270 days (9 months) after the last day of the provider's fiscal year ending date, except for government agencies, whose audits are due 12 months after their fiscal end date. The contract manager reviews each audit according to the "Checklist for Reviewing Single Audit CPA Reports," and if there are findings; the provider is required to present a corrective action plan to their contract manager. The corrective action plan is tracked until the corrective action is completed. While not required to be used, but useful when there are multiple findings to track, an "AUDIT Corrective Action Guide for Contract Providers" is available for provider use.

C. Network System and Information Security

All Child Protection Team main sites and certain designated satellite offices require DOH Network connectivity to access DOH email and approved data systems. Through the department's network providers have access to the Department of Children and Families (DCF) Network for CPT mandated abuse report functions. These connections are maintained and supported by DOH Division of Information Technology and CMS Distributed Computer System Analysts (DCSAs). A local CMS DCSA is assigned to each Child Protection Team to provide technical support for these connections. The provider must report any technical problems with the use of the connection or the equipment connected to the Health Network to their designated CMS DCSA.

Arranging and paying for the data connection and internal building wiring is the responsibility of the individual provider. This is an allowable cost that may be budgeted as an expense in the CPT contract program budget. The Department of Management Services (DMS) bills the provider directly for monthly data line costs. It is the provider's responsibility to ensure prompt payment to DMS.

1. Changes and New Connections

When the provider is moving its office site, the CMS Program Office and the DCSA must be informed of the planned move date and the new site information 90 days prior to the effective date of the move. Lead time is needed in order for the timely installation of the connection at the new site. New site connection requests will be reviewed as to their cost benefit by the CMS Program Office.

2. DOH Authorized Users

Child Protection Team provider staff and subcontractors must be approved by the CMS Program Office as authorized users. They must have completed the DOH Security Information training in the Trak-It System, and signed the DOH "Confidentiality and Security Statement of Understanding" prior to being given access to the DOH network. Thereafter all appropriate CPT staff and subcontractors are required to retake the test annually.

The "Request to Add/Delete Authorized Users" form must be completed and signed by the requestor and the team coordinator and sent to the CMS Program Office before a new user

access can be created. The Certificate of Completion (DOH Security Test) must be attached. The CMS Program Office must also be advised and a user change document provided when a user's authorization needs to be terminated or changed.

Team Coordinators, or their designee, are responsible for timely submission of the form to remove an individual's access to the Network and data system no later than the last day of employment.

3. Child Protection Team Information System (CPTIS)

The department maintains a CPT web-based data management system for the CPT program for which the CMS Program Office provides technical and management support. The provider is required to participate in entering all client data in CPTIS, and has the responsibility of ensuring the quality of the data.

4. The DOH Intranet

The Intranet has information about the department and its operations, policies and requirements. While departmental policy in certain areas is applicable to providers, the applicability of policy and protocols for providers varies. The initial contact person regarding any policy or protocol information on the DOH Intranet is your CPT contract manager.

5. Protection and Security of Equipment

The provider is responsible for the protection of electronic confidential information. Any security breach or lost or stolen equipment must be reported immediately to the contract manager and the local CMS DCSA. See sections D (Information Security) and E (Asset [Tangible Property] Management) for additional information related to equipment security requirements.

D. Information Security

Information Security Policy and CPT/Telehealth/SATP supplemental policy and procedures are contained in your CPT Resource Book, which contains specific requirements for CPT providers. It also addresses information considered to be confidential and how to protect confidential information, both in hard copy and in electronic format.

1. Child Protection Team Program Specific Confidentiality

Section 39.202(6), Florida Statutes (2012) primarily governs the release of records and reports of child protection teams (CPTs):

- CPT records may be deemed to include all electronic and physical records made by CPTs within the scope of CPT duties and responsibilities under section 39.303, Florida Statutes. (This does not include administrative and business records.)
- CPT records are confidential
- CPT records are exempt from section 119.07(1), Florida Statutes (public records disclosure)
- CPT records are exempt from section 456.057, Florida Statutes (medical records disclosure)
- CPT records may be released upon request to:

- ✓ State attorney
- ✓ Law enforcement
- ✓ Department of Children and Family Services
- ✓ Necessary professionals in furtherance of treatment or additional evaluative needs
- ✓ Health plan payers—limited to information used for insurance reimbursement, and
- ✓ By order of court

CPT records, client demographic data or any CPT client specific information may not be shared within an agency (this includes agency data systems) unless covered by one of the above criteria.

CAVEAT: Release upon request to authorized agencies is tempered by proper identification and the requestor's need to know. Release upon request to authorized agencies is not an open invitation for any employee of those agencies to request and receive CPT records without a legitimate need to have access to those records in order to perform their official duties.

ADDITIONAL STATUTORY AUTHORITY For Release Of CPT Records

- Child Abuse Death Review Committees: Under section 383.402(8), Florida Statutes, the chairperson of the Statewide Child Abuse Death Review Committee and the chairpersons of duly designated local child abuse death review committees may have access to CPT records.

RELEASE PROHIBITED: CPT records may **not** be released by means of:

- Subpoena duces tecum (identifies documents subject to the subpoena), except from state attorney or chairperson of the Statewide Child Abuse Death Review Committee, or other subpoena (not duces tecum) for deposition or to testify
- Consent for release by a child or the child's parent, legal guardian, legal custodian, guardian ad litem, attorney ad litem, or legal representative

CONTINUING CONFIDENTIALITY: Generally, the confidential and exempt status of CPT records attaches to the documents; that is, it retains its confidential and exempt status when it is properly released to an authorized agency or person, who in turn generally have a legal obligation to maintain the confidential and exempt nature of the documents.

All CPT reports must have the following statement of confidentiality included in all written reports:

"Pursuant to section 39.202(6): All records and reports of the child protection team of the Department of Health are confidential and exempt from the provisions of ss. 119.07(1) and 456.057, and shall not be disclosed, except, upon request, to the state attorney, law enforcement, the department, and necessary professionals, in furtherance of the treatment or additional evaluative needs of the child, by order of the court, or to health plan payors, limited to that information used for insurance reimbursement purposes.

Pursuant to 39.205 (3) A person who knowingly and willfully makes public or discloses any confidential information contained in the central abuse hotline or in the records of any child abuse, abandonment, or neglect case, except as provided in this chapter, commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

DISCOVERY EXCEPTION:

- CPT records in possession of the state attorney, law enforcement, and the Department of Children and Family Services are discoverable in dependency cases, under Rule of Juvenile Procedure 8.245, and in criminal cases, under Rule of Criminal Procedure 3.220. *B.B. v. Dept. of Children and Family Services*, 731 So. 2d 30 (Fla. 4th DCA 1999).
- Those authorized agencies may release CPT records in their possession pursuant to the applicable rules of discovery, without a court order or review by CPT.
- CPTs are not a “party” in dependency and criminal proceedings; however, CPT personnel and experts are often material witnesses, and they are subject to properly served subpoenas to appear and testify at depositions, hearings, and trials for dependency and criminal proceedings. (Remember, for depositions, CPT personnel may testify about CPT records already obtained through discovery; however, a subpoena duces tecum from defense counsel is not adequate to release CPT records, whether already received by counsel in discovery or not. At a hearing or trial, a judge is available to rule on the release of any records.)

CAVEAT: CPTs should involve their team attorney whenever the team receives a subpoena, discovery request, or court order that in anyway appears out of the ordinary or raises any questions about how to respond. Similarly, CPTs should ask their team attorney to review any request for CPT records from any person or organization not discussed herein.

2. Annual Information Security Risk Assessment

Each provider must complete an annual Security Checklist utilizing the CMS Program Office form. This is an annual self assessment review and must be completed and sent to the contract manager.

E. Asset (Tangible Property) Management

For purposes of this section, non-expendable property is defined as tangible personal property of a non-consumable nature that has an acquisition cost of \$1000 or more per unit and an expected useful life of at least one year. This section provides information and contract requirements for two types of tangible non-expendable property. These two types of property are distinguished by ownership rights and responsibilities.

1. Provider Property Purchased with Child Protection Team Contract Program Revenue - Ownership of Provider Purchased Non-Expendable Property

This is non-expendable property purchased by the contract provider in part or in whole with CPT contract program revenue: Title to this property is held by the provider but is subject to certain conditions. Refer to Attachment I of the CPT contract, Section D.3 entitled “Non-Expendable Property”. This states that the property acquired under the contract and all renewals must be

vested in the department upon completion or termination of the contract. In other words, the department has the right to take title to the property in the event the contract is terminated. However, other asset management provisions of this Section D.3 are in effect.

2. Annual Contract Inventory for Non-Expendable Property

An annual physical inventory must be completed of tangible non-expendable property purchased in whole, or in part, with CPT program revenue. A copy of the annual up-to-date contract inventory must be provided to the contract manager within 45 days of the end of each contract year and should include the following:

- a. a description of the property,
- b. the model number,
- c. the manufacturer's serial number, and
- d. the funding source.
- e. date of acquisition,
- f. corresponding contract #,
- g. unit acquisition cost,
- h. provider's property inventory number,
- i. use, and
- j. the location of the property by site address and room number

"Use" (i) in this case means "CPT" program functions. While the provider agency may use its own inventory format, the CMS Program Office "Inventory Worksheet Guide" is preferred as its format includes all of the information required. If the provider has never purchased any property since providing CPT contract services, return a copy of the Inventory Worksheet Guide with provider identification and indicate "none" in the chart area.

3. Maintenance of Contract Equipment

The provider is responsible for maintaining this equipment in working order and arranging and paying for any maintenance costs or upgrades of the equipment while the contract is in effect. These expenses are to be budgeted in the CPT contract program budget. Informational technical assistance should be sought from the local CMS DCSA to ensure that the equipment continues to meet the department's standards. Under no circumstances should equipment or upgrades be purchased without CMS Program Office IRR approval.

4. Use of Provider Equipment

The equipment purchased with CPT contract program revenue must be used for activities necessary to perform services specified in the contract. Provider personnel who spend a significant portion of their work time supporting the CPT program may use this equipment. This equipment may also be assigned to the CPT Medical Director or to other CPT professional providers with the concurrence of the CPT Medical Director. CPT equipment (i.e. servers, printers) not connected to the DOH network, may be shared by other provider staff for promoting the agency's overall service delivery. Only authorized DOH users may use equipment that is connected to the DOH network.

5. Disposal of Contract Inventory – Certification of Non-Expendable Property as Surplus

Disposal of non-expendable property, either owned by the provider or department requires the permission of the department per DOHP-250-11-12, "Management of State-Owned Property." While some property is considered owned by the provider (agency), provider use of department funds in part or whole to purchase equipment, the department reserves the right to take title should the contract be terminated for any reason. The protocol for disposal requires the department's written certification of the property as "surplus". The department's "Certification of State Surplus Property" DH1100 form must be completed and submitted to the contract manager to initiate the process for disposal of the property. The provider must maintain physical custody of the equipment until such time as they receive approval from the program office to dispose.

6. Protocol for Disposal – Surplus Certification

It is imperative that all disposal action be documented and supporting documentation be kept in the inventory section of the provider contract file for the fiscal year in which the disposal was completed. The following are the steps to be taken:

- a. Identify the equipment that is to be certified as surplus for disposal on the DOH 1100 form "Certificate of State Surplus Property. Make sure that all appropriate equipment has been sanitized and the CMS DCSA has signed and noted the method of sanitization.
- b. Develop a plan for disposal and put in written memo form to the contract manager
- c. Submit the completed "Certificate of State Surplus Property", along with the provider memo describing how the provider will surplus the equipment once final approval is received from the CMS Program Office, to the contract manager. The form will not be reviewed or approved unless completely filled out with all appropriate provider and IT signatures.
- d. The contract manager will work with the DOH Support Services Section and the CMS System Analyst to arrange for the posting of the equipment on the department's Asset Management System, surplus property report. These items will remain on the report for 14 days during which another state agency may request the equipment. If this occurs, it would take precedent over the plan for donation to a non-profit organization.
- e. The contract manager will notify provider of authorization to dispose of the property after the posting is completed and no requests for the property have been made.
- f. The provider must ensure that all property tags are removed from the equipment prior to disposal.
- g. Property may be disposed of in the following acceptable ways:
 1. Donation to Private Non-Profit Organization – In order for the non-profit organization to receive the asset, it must produce a current 501C3 letter from the federal government or Florida Certificate of Exemption denoting the organization has

met the federal 501C3 certifying them as a non-profit. If the organization can not produce this document, the assets can not be donated to it.

2. Sales – Sales to department employees or provider staff, excluding those sales open to the general public are not permitted. All proceeds from these sales will be collected and deposited.

3. Cannibalizing or Scrapping – Non expendable property may be disposed of in landfills or other appropriate sites, such as recycling, or through cannibalizing for usable parts. This disposal procedure should include the following steps:

- a. Removal of asset decals/property tags
- b. Disassembling of asset (when possible)
- c. If any part of the asset can be recycled, it should be recycled prior to cannibalizing or scrapping the asset
- d. All costs incurred in the disposing of assets must be the responsibility of the disposition entity (provider). Maintain receipts to validate method of disposition
- e. If any of the equipment is an information technology asset, it will need to meet DOH standards for sanitization of information technology assets. The local DCSA should be contacted to either sanitize the equipment or ensure methods to be used meet the DOH standards prior to disposition.

Once it is decided that this equipment is no longer useful in the CPT contract program, it becomes “surplus,” is “disposed of,” and removed from the CPT contract inventory. Example: If an agency finds the equipment is no longer needed or useful in the CPT contract program, it may surplus the equipment and donates it to another program within the same agency.

Special dispositions:

- Provider purchased and owned Telemedicine equipment being given to another CPT: indicate the CPT Team I.D. in the last column. The receiving team will need to add the equipment to its inventory upon receipt.
- Telemedicine equipment being donated to DOH –CMS’s Special Technologies Unit or Telemedicine equipment being donated to other than DOH: No plan for disposing of contract purchased telemedicine equipment should be made without discussing it with the DOH-CMS Telehealth Technology Unit.
- If, after exploring all the options above for equipment that is in workable condition, no party has been identified to receive the equipment and the only option left appears to be “scrap”, then it may be possible to donate the equipment to other than a non-profit agency. Contact the CMS contract manager if this status is reached. Under no circumstances can equipment be donated to employees of the provider agency. However, employees and the general public may buy equipment at a public auction.

h. Provide the following documentation to the CMS contract manager upon disposal of property:

- 1) A signed and dated receipt on the letterhead of the party receiving the equipment with each item detailed on the receipt.

- 2) If scraping, email the contract manager with the name of the vendor who will dispose of the equipment according to the local county environmental standards. Keep a receipt of the scraping agency in the team's contract file or a copy of the paid invoice from the vendor.

7. Contract Termination and Expendable Property (less than \$1,000) Purchased by Provider

See the contract's Attachment I, Section D, and "Termination Process." While expendable tangible property purchased by the provider is not required to be inventoried annually, title to all property bought with state funds, regardless of dollar amount, is vested in the department upon completion or termination of the contract. Therefore, the provider must maintain an inventory of all equipment. At the time of completion or termination of a CPT contract, the provider must follow the department's instructions as to the disposition of all tangible non-expendable and expendable property.

F. Department (DOH) Owned Equipment Deployed to Provider

Department equipment, including all non-expendable and expendable of a general office, medical, or data processing type, must be used for contracted CPT service provision only, in accordance with any additional department instructions, including any security program-specific supplemental protocols referenced in the CPT Resource Book.

1. Specific Use of DOH owned equipment.

The equipment purchased with DOH revenue must be used for activities necessary to perform services specified in the contract. Provider personnel who spend a significant portion of their work time supporting the CPT program may use this equipment. Except for DOH owned laptops which require written approval from the contract manager, DOH owned equipment may also be used by the CPT Medical Director or other CPT professional providers with the concurrence of the CPT Medical Director. Child Protection Team equipment (i.e. servers, printers) not connected to the DOH network, may be shared by other provider staff for promoting the agency's overall service delivery. DOH shared equipment may be used on the provider's LAN when the majority of the users on the provider's LAN are CPT provider personnel. Only authorized DOH users may use equipment that is connected to the DOH network.

2. Maintenance of DOH owned equipment.

The department will arrange for and pay for all maintenance, upgrades and repairs of DOH owned equipment. Non-functioning equipment should be brought to the attention of the local CMS DCSA and the contract manager. The CMS DCSA will work with the CMS Program Office to arrange and pay for the repair or upgrading of DOH equipment. At no time must the provider alter or have altered any DOH equipment (hardware or software) without the department's written approval.

3. Provider's Responsibilities for DOH equipment.

The provider must:

- a. Obtain the department's written approval prior to moving any equipment to a physical site other than the site indicated at the last annual inventory, so as to ensure that DOH's fire insurance carrier has accurate information regarding the site location. The provider will also be asked to provide pertinent information about any new physical site.
- b. Immediately notify local law enforcement and the CMS Program Office of any lost or stolen equipment.
- c. Cooperate fully in the DOH annual inventory of its equipment within the established deadlines.
- d. Immediately notify the department of any casualty loss.
- e. Immediately notify CMS Program Office when new DOH equipment is received. Provide the information needed for DOH payment and immediately place the DOH decals on new equipment when received. At any time it is discovered that a decal has been removed or destroyed, advise the CMS Program Office of the need for DOH replacement decals.

4. Procedure for Disposal of State-owned (deployed at provider site) Non-expendable Property

DOH property is any property (regardless of acquisition cost) that has been designated as an item to be inventoried and has been given property tag #. An example of such equipment is the Optra T series Lexmark printers that are deployed to CPT providers.

DOH property also includes the following:

- B. Former Department of Health and Rehabilitative Services property
- C. Property transferred to the Department of Health by the Department of Children and Families at the time the CPT program was transferred to DOH
- D. Any equipment purchased by DOH and deployed to the CPTs

The procedure for requesting disposal of DOH equipment that is deployed to the provider is the same as that of the provider owned property; however the DOH equipment should be separately identified on the Certification of State Surplus Property, DOH1100 form. If the provider anticipates a cost for disposing of DOH equipment, DOH can pay for this type of expenditure. The contract manager should be contacted if this is the case; however no cost will be covered by DOH unless a formal DOH authorization (Purchase Order) was issued prior to incurring the cost.

G. Child Protection Team Medical Oversight

This section provides the standards, requirements, benefits, and related protocols for the medical oversight of the CPT program. It covers all CMS physicians designated as CPT Medical Director and addresses specific medical supervision protocol for physicians and other medical personnel.

1. CMS and CPT Physician Standards, Role and Functions, Malpractice Coverage and Dispute Resolution Standards.

Any physician designated as a statewide or team medical director or team physician must meet the standards specified in the CMS Physician's Handbook and be an approved CMS physician. This Handbook is posted on the DOH Internet under CMS. Additional CPT specific personnel qualifications and responsibilities are listed in Appendix A of this Handbook. Waiver of any of these standards can only be granted by the Deputy Secretary for CMS.

2. Roles.

The CMS Physician's Handbook (CPT Provisions) specifies standards and outlines medical oversight roles and relationships between CPT physicians, DOH, contracted providers, and other physicians. Specific personnel qualifications and responsibilities are addressed in Appendix A of this CPT Handbook.

3. Malpractice Coverage.

The CPT section of the CMS Physician's Manual addresses the area of malpractice coverage and sovereign immunity for provision of services to the extent provided by law.

According to DOH Risk Management, CPT medical providers appear to act under the color of law and are agents of the state when they examine children allegedly abused or neglected under Section 39, F.S. Risk management further acknowledged that they would be able to provide coverage for medical directors and medical providers in the event of liability lawsuits that arise from Section 39, F.S.

H. Employment Status Requirements and Compensation

1. Employment Status and Requirements.

The Statewide Medical Director and the team Medical Directors must meet the CMS and CPT specific standards outlined elsewhere in this section. The Surgeon General of the Department of Health, with the concurrence of the Secretary of DCF, appoints individuals to these positions.

CPT Medical Directors who become DOH OPS employees must meet all the applicable OPS requirements of the DOH Employee Handbook (available on the DOH Intranet). Any CPT physician who is employed by a DOH contract provider must also meet the requirements of the contract under the auspices of the provider agency.

2. Negotiation of Compensation for Child Protection Team Medical Directors.

Regardless of the method of compensation, the rate of pay is negotiated between the department and the individual or the individual's contract provider based on the willing individual physician's expertise and experience and a reasonable and necessary rate for a specified time period, usually on an annual basis. A minimum (adjusted when across the board increases have been given in the past) standard rate of pay for 8 hours a week is the guide for beginning negotiations.

3. Sub-contracts - Compensation for Child Protection Team Medical Directors.

Medical evaluation services and CPT related travel must be compensated for by the CPT contract provider. Sub-contracts must not include any of the medical oversight functions.

4. Information Security Training.

All CPT physicians noted in the first paragraph of this sub-section, regardless of their employment status, must complete the DOH Security Information training when appointed and annually thereafter.

I. Performance Specifications

The following performance specifications apply to all CPT Medical Directors, regardless of method of compensation:

1. Service Definition

All medical oversight functions must be performed in compliance with the designated team's CPT contract requirements and any corrective action indicated as a result of a quality assurance review of the team.

2. Unit of Service

A unit of service consists of carrying out the CPT medical director functions for a period of one month.

3. Specific Standard

The successful completion of CPT medical director functions, on-going throughout a state fiscal year.

4. Methodology for Measurement

The completion of functions will be considered successful when the annual monitoring report of the CPT Medical Director's designated team(s) indicates the standards are met or corrective action taken in accordance with the standards and terms of the CPT provider's contract.

5. Monitoring and Evaluation Methodology

The performance of the CPT Medical Director must be reviewed by the statewide Medical Director, at a minimum, at the end of each annual state fiscal year.

J. Provider Subcontracts – Approval Process

Providers whose contracts were procured through the exemption process, listed in section 287.057 (5) (f), Florida Statute, must request approval from DOH to subcontract their services. The following must be provided to the DOH contract manager prior to the provider executing the subcontracts:

1. The written justification for the need of a subcontractor.

2. A copy of the proposed subcontract
3. The completed subcontractor form which identifies the name of the subcontractor and the type of business organization (sole proprietor, partnership, corporation), whether they are an entity or provide a service or commodity, which is exempt from competitive procurement.
4. The percentage of the provider contract to be paid to the subcontractor
5. Any current or former DOH employees employed by the subcontractor and whether they were involved in the procurement process.
6. Whether the subcontractor has any other contracts with DOH and what the contract numbers are.
7. Documentation of Debarment Search on the provider.
8. Determination of sub recipient or vendor.

Once all this information is provided, the contract manager must meet with the Division Director and attorney assigned to the division and determine whether the request for subcontractor approval must be granted and under what terms and conditions.

Appendix C: Glossary

Abandonment – A situation in which the parent or legal custodian of a child or, in the absence of a parent or legal custodian, the caregiver responsible for the child's welfare, while being able, makes no provision for the child's support and makes no effort to communicate with the child, which situation is sufficient to evince a willful rejection of parental obligations.

Abuse - Any willful act or threatened act that results in any physical, mental, or sexual injury or harm that causes or is likely to cause the child's physical, mental, or emotional health to be significantly impaired. Abuse of a child includes acts or omissions. Corporal discipline of a child by a parent or legal custodian for disciplinary purposes does not in itself constitute abuse when it does not result in harm to the child.

Allegation Matrix - The Department of Children and Families document that defines each specific type of abuse, abandonment, or neglect; guides department staff or designated representative in determining whether abuse, abandonment or neglect has occurred; and helps to ensure that all factors are considered when assessing specific types of maltreatment.

ARNP - Advanced Registered Nurse Practitioner.

At Risk - The likelihood that a child will be abused or neglected in the near future without intervention.

Assessment Activities - Services provided by child protection teams. Assessment activities include: medical evaluations, medical consultations, psychological evaluations, psychological record reviews, specialized and forensic interviews, social assessments, nursing assessments, and CPT staffings.

Background Screening – The fingerprint based search of criminal records. All positions of special trust or responsibility as defined in F.S. 110.1127(3)a, are required to have a level 2 background screening which is a fingerprint based search of criminal records in Florida and nationally.

Case - An individual child referred to and accepted by a child protection team for assessment services as a result of a report of alleged abuse or neglect made to the Hotline.

Case Progress Notes Record – Case documentation in CPTIS which provides details on all case activities completed. This includes dates, times, individual contacted, assessment activity completed, and summary of the activity.

Case Coordination - Those activities that are provided on behalf of clients to complete a team assessment (e.g., contacts to arrange specific assessments, case activities and collateral contacts with law enforcement, state's attorney, DCF, GAL, schools).

Case Coordinator - A member of the child protection team professional staff who provides or directs the assessment activities on behalf of clients.

Case Documentation – Consists of all material and photographs in the case file.

Case Review - A formalized internal process for supervisory review of the content, status and progress of completing the team assessment services. Case reviews must be documented in the case progress notes in CPTIS.

Child - Any unmarried person under the age of 18 years who has not been emancipated by order of the court. [s. 39.01 (12), F.S.]

Child Protection Staff - Refers to Department of Children and Families or Sheriff's Office Child Protective Investigators (CPIs), and community based care (CBC) case managers who provide protective services supervision, foster care, and/or adoption services.

Child Protection Team (CPT) - A medically led multidisciplinary team available to supplement the child protection activities of DCF or designated community-based providers and sheriff's offices.

Child Protection Team Medical Director – The CMS approved pediatrician responsible for overall direction and supervision of a child protection team.

Child Protection Team Information System (CPTIS) - The web-based application developed for the collection and reporting of CPT client and service information.

Child Protection Team Information System Report – System generated management, performance reports based on individual, team and statewide data.

Child Protection Team Resource Book – A notebook that contains all the current law, rules, operation procedures, contract, and information pertaining to the functioning of the CPT program. Each team is responsible for keeping this notebook up to date and in a common area assessable to all CPT staff.

Child Protective Investigator (CPI) – The individual employed by the Department of Children and Families or by the local Sheriff's Office, who is responsible for investigating allegations of abuse, neglect, and/or abandonment of children by a caretaker.

Children's Medical Services (CMS) - The Children's Medical Services Program within the Department of Health.

CMS Consultant Physician - A physician who is an approved CMS medical provider licensed to practice in the state of Florida. All CPT medical directors and contracted physicians must be CMS approved physicians.

Community Based Care (CBC) Provider - A provider contracted with DCF to perform specific child protection functions (e.g., protective services, foster care or adoptions).

COOP – Continuity of Operations Plan – A mandated initiative to ensure that will provide for the prompt and effective continuation of critical program functions in the event of a disaster, natural or manmade.

Court Activity (Testimony/Deposition) - The sworn or affirmed testimony in or out of court by a member of the CPT.

Department of Children and Families (DCF) – As it pertains to Child Protection Teams, the state agency responsible, either directly or through contracted providers, for receiving child abuse—reports, case management of dependency court ordered and voluntary protective services, foster care, licensing and adoption services. DCF CPIs are responsible for child abuse, neglect, and/or abandonment investigations by a parent or caretaker responsible for the child's welfare.

Department of Health (DOH) - The public health agency responsible for the health and safety of all citizens in the state.

Developmental Screenings – A checklist is used to determine if an infant or toddler, birth to 36 months of age, has a condition or concern that may make the child eligible for early intervention.

Electronic Case File— documentation in CPTIS necessary to provide a comprehensive record of CPT involvement with the child.

Florida Safe Families Network – The DCF web-based information system that contains Child Safety Assessments (CSAs) generated by the Hotline for investigation; protective services supervision, foster care, or adoption case information; and all available information concerning children and families who have been referred for investigation of abuse, abandonment, or neglect. This system replaced the DCF HomeSafeNet system which replaced the Florida Abuse Hotline Information System (FAHIS).

Final Case Summary – The document completed upon case closure.

Hotline - The receiving point in DCF for all calls regarding reported cases of suspected abuse, neglect, or exploitation of children, disabled adults and the elderly.

Intake Referral – The documentation of the discussion between the case coordinator and referral source regarding appropriateness of providing CPT assessment services, or whether services are not warranted.

Interim Case Summary – A status report sent to the CPI if the CPT case remains open 20 days following the date of referral (the day after referral receipt counted as day one).

Neglect - When a child is deprived of, or is allowed to be deprived of necessary food, clothing, shelter, or medical treatment or a child is permitted to live in an environment when such deprivation or environment causes the child's physical, mental, or emotional health to be significantly impaired or to be in danger of being significantly impaired. Neglect is an omission which is a serious disregard of parental responsibilities for the child's welfare including:

- Prolonged or repeated lack of supervision or failure to exercise a minimum degree of care that resulted in injury or harm.
- Failure to make reasonable efforts to stop the actions of another person, which resulted in injury or harm.

Refer to Section 39.01(45) FS for clarification of neglect based on financial inability or religious beliefs.

PA – Physician's Assistant

Physician Training - Training provided to physicians and other medical personnel on the detection of child abuse and neglect.

Other Training - Training provided to other professionals such as DCF staff or other members of the community involved in the identification or determination of abuse or neglect and may include public and media presentations on child abuse.

Referral - The discussion between the CPI and CPT case coordinator where the current abuse report allegations, CPI interview information and prior reports are discussed at length to determine if CPT assessment services are appropriate or not warranted.

Referral Source – The source of the initial referral. In a majority of the cases, the referral source will be the CPI; however the initial referral may come from other involved professionals (e.g., law enforcement, hospitals, physicians, and CBC case managers).

RN – Registered Nurse

Risk Factors – Conditions and/or behaviors that create a threat to the child's safety or risk of maltreatment. (Environmental, developmental, behavioral, medical as well as the composition of the family unit are factors that would be assessed when determining the abuse/neglect dynamics that impact on the overall level of risk to a child.)

Session - Use of the telemedicine network for the medical examination/diagnosis of a child alleged to be abused or neglected.

STD – Sexually Transmitted Disease

STD Prophylactic Medication – medication used in the prevention of STD for sexual assault in adolescents and pre-pubertal children referred to the CPT for medical evaluation.

Team Coordinator - The person in charge of managing the day to day operation of a CPT.

Telemedicine - Telemedicine is defined as the use of telecommunication and information technology to provide clinical care to individuals at a distance and to transmit the information needed to provide that care.

Threatened Harm – Behavior that is not accidental and which is likely to result in harm to the child.

Waiver - A written request for the waiver submitted by a contract provider to the Children's Medical Services Program Office. The request for waiver of a personnel standard as defined in Chapter 64C-8, Florida Administrative Code, must include documentation of the need for the waiver and follow protocol established by the Program Office.

Appendix D **DEVELOPMENTAL SCREENING EARLY STEPS (ES) CHECKLIST**

This checklist is used to determine if an infant or toddler, birth to 36 months of age, has a condition or concern that may make the child eligible for early intervention. ***The checklist can be used by a professional (physician, nurse, social worker, child welfare worker, and so on) or any other practitioner to make a referral for early intervention.*** If you are concerned that a child has one or more of the conditions listed, you should consider referring the child to Early Steps. A copy of the ES Checklist and Referral Form must be included in the CPT case file. **(PROVIDE A COPY OF THIS CHECKLIST TO LOCAL ES PROGRAM WITH REFERRAL FORM).**

Child's Name _____ Date of Birth _____ Age _____
 Parent/Caregiver Name _____ Telephone _____
 Address _____
 City _____ State _____ Zip Code _____

This checklist includes many but not all of the conditions or concerns that may make a child eligible for early intervention. If a child has any condition or concern that has a ***high probability of being associated with a developmental delay or poor behavioral outcome*** the child should be referred for early intervention services.

CERTIFIED CONDITION	<p style="text-align: center;">SECTION 1</p> <p><input type="checkbox"/> <input type="checkbox"/> Hearing Impairment</p> <p><input type="checkbox"/> <input type="checkbox"/> Visual Impairment/blind</p> <p><input type="checkbox"/> <input type="checkbox"/> Chromosome anomaly (<i>such as Down's Syndrome</i>)</p> <p><input type="checkbox"/> <input type="checkbox"/> Neurological condition (<i>such as Cerebral Palsy</i>)</p> <p><input type="checkbox"/> <input type="checkbox"/> Seizure Disorder (<i>such as epilepsy</i>)</p> <p><input type="checkbox"/> <input type="checkbox"/> Physical abnormality/abnormal movement</p> <p><input type="checkbox"/> <input type="checkbox"/> _____</p>
DEVELOPMENTAL DELAYS	<p style="text-align: center;">SECTION 2</p> <p><input type="checkbox"/> <input type="checkbox"/> 3 months and child does not watch moving objects or respond to sounds</p> <p><input type="checkbox"/> <input type="checkbox"/> 6 months and unable to roll over</p> <p><input type="checkbox"/> <input type="checkbox"/> 9 months and unable to sit alone</p> <p><input type="checkbox"/> <input type="checkbox"/> 12 months and unable to crawl (<i>or crawls with great difficulty</i>)</p> <p><input type="checkbox"/> <input type="checkbox"/> 15 months unable to stand alone</p> <p><input type="checkbox"/> <input type="checkbox"/> 15 months and unable to hold a cup</p> <p><input type="checkbox"/> <input type="checkbox"/> 18 months and has no speech or only babbles</p> <p><input type="checkbox"/> <input type="checkbox"/> 18 months and unable to walk</p> <p><input type="checkbox"/> <input type="checkbox"/> 24 months and unable to use objects like crayons or spoons</p> <p><input type="checkbox"/> <input type="checkbox"/> 24 months and does not engage in play or social interaction</p> <p><input type="checkbox"/> <input type="checkbox"/> _____</p>
OTHER CONCERNS	<p style="text-align: center;">SECTION 3</p> <p><input type="checkbox"/> <input type="checkbox"/> Feeding/Eating difficulty</p> <p><input type="checkbox"/> <input type="checkbox"/> Shaken Baby/Head Injury</p> <p><input type="checkbox"/> <input type="checkbox"/> Chronic illness</p> <p><input type="checkbox"/> <input type="checkbox"/> Child in hospital or recent hospitalization</p> <p><input type="checkbox"/> <input type="checkbox"/> Child extremely underweight or appears malnourished</p> <p><input type="checkbox"/> <input type="checkbox"/> Lack of eye contact or lack of interest in interaction with parent/caregiver</p>

	<input type="checkbox"/> <input type="checkbox"/> _____
	If you checked any of the Boxes above, a referral to the local Early Steps provider is appropriate.

CPT STAFF/PHONE NUMBER

DATE Checklist Completed

EARLY STEP REFERRAL FORM

**WHEN MAKING A REFERRAL TO LOCAL ES PROGRAM PROVIDE A COPY OF THE
ES CHECKLIST AND THE REFERRAL FORM**

Referring Agency: _____

Reason for referral:

Date of referral: _____

CPT Staff/Phone Number:

**APPENDIX E:
INTERAGENCY AGREEMENT
THE FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
and
THE FLORIDA DEPARTMENT OF HEALTH, CHILDREN'S MEDICAL SERVICES,
EARLY STEPS**

I. PURPOSE

The purpose of this agreement between the Department of Children and Families, Office of Family Safety and the Department of Health, Children's Medical Services, Early Steps is to ensure that children under the age of three who are involved in substantiated cases of child abuse or neglect and are potentially eligible for early intervention services are referred to the local Early Steps office within their region when warranted. This process will include Child Protective Investigators, Sheriff's Protective Investigators, Community Based Care Lead Agencies and Local Early Steps. This agreement describes referral procedures for early intervention services provided through the Part C system under the Individuals with Disabilities Education Act (IDEA).

II. PARTICIPATING PROGRAM INFORMATION

Florida Department of Health (DOH) – The mission of DOH is to promote and protect the health and safety of all Floridians. It is the state's lead agency for early intervention services provided under the Individuals with Disabilities Education Act (IDEA) Part C, a federal entitlement program. In Florida, Part C services are administered by Early Steps, Children's Medical Services within the Department of Health

- **Children's Medical Services (CMS)** – CMS provides services to children with special health care needs through a family-centered managed system of care. Services are provided through an integrated statewide system that includes local, regional and tertiary care facilities and providers.

- **Early Steps** - Early Steps is a statewide family-focused, multidisciplinary, system of early intervention services for eligible infants and toddlers, birth to thirty-six months, with a developmental delay or an established condition likely to result in developmental delay. Services are provided by 16 Early Steps offices (referred to as the Local Early Steps) that are contracted through community based organizations across the State of Florida. The Early Steps system has the following components: the Developmental Evaluation and Intervention (DEI) Program, the IDEA Part C Program, and services provided under Section 393 Florida Statutes for children birth to thirty-six months. Florida Department of Children and Families (DCF): The mission of DCF is to protect the vulnerable and promote strong and economically self sufficient families, in addition to advancing personal and family recovery and resiliency. 11/30/2007 1

- **Office of Family Safety** - The Office of Family Safety in DCF is responsible for policy development and oversight of child protection. Its functions include support for state and private programs that help child victims of abuse and neglect and support and promotion of the adoption of foster children.

III. REQUIREMENTS IMPACTING THIS AGREEMENT

The Child Abuse Prevention and Treatment Act (CAPTA) has a significant requirement for States to have provisions and procedures for the referral of children under the age of three who are involved in substantiated cases of child abuse or neglect to early intervention services under Part C of the IDEA [42 U.S.C. 5106a, Sec. 106 (b)(2)(A)(xxi)]. Florida has defined "substantiated" as any case with verified findings of child abuse or neglect. In addition, the federal Individuals with Disabilities Education Improvement Act of 2004 contains requirements regarding the referral of children to Part C who are under the age of three and involved in a substantiated case of abuse or neglect or affected by illegal substance abuse or withdrawal symptoms from prenatal drug exposure (20 U.S.C., Sections 1437(a)(6)(A) and (B)).

IV. DEFINITION OF TERMS

- **Abuse** – Any willful or threatened act that results in any physical, mental, or sexual injury or harm that causes or is likely to cause the child's physical, mental, or emotional health to be significantly impaired. Abuse of a child includes acts or omissions. Corporal discipline of a child by a parent or legal custodian for disciplinary purposes does not in itself constitute abuse when it does not result in harm to the child.
- **Case Plan Development Process** – The process during which a case plan as defined in Section 39.01(11), Florida Statute, is jointly developed between the family and the services worker, delineating specific interventions aimed at addressing the contributing factors and underlying conditions that lead to child maltreatment.
- **Community-Based Care (CBC) Program** - A system of care for the provision of all child welfare services, with the exception of child protective investigations. The delivery model utilizes privatized contractors to determine the needs and develop the resources for the community being served, in addition to meeting core requirements outlined in federal laws and regulations, Florida Statute or in Florida Administrative Code, or as stipulated per contract with the DCF.
- **Established condition** – A physical or mental condition that has a high probability of resulting in disability or developmental delay.
- **Evaluation** - The procedures used by appropriate qualified personnel to determine a child's initial and continuing eligibility for Early Steps, including determining the status of the child in each area of development.
- **Individualized Family Support Plan** - A written plan of early intervention services designed to meet the identified outcomes for an individual child and family that 11/30/2007 2 is developed by the family, evaluators, the service coordinator, service providers and others.
- **Florida Abuse Hotline Information System** - 1-800 line for reporting child abuse, neglect or abandonment, in addition to reporting abuse neglect or exploitation of vulnerable adults.
- **Lead Agency**– An “eligible lead community-based provider” for DCF as defined in Section 409.1671(1)(e), F.S. The functions of a lead agency include the following:
 - Organize and manage a network of service providers;
 - Provide case management for any children/families referred;
 - Purchase/provide all necessary services to ensure permanency;
 - Maintain and report required client and performance data; and
 - Assume and manage financial risk (capped budget for all required services).
- **Medicaid Comprehensive Behavioral Health Assessment** – An in-depth and detailed assessment, consisting of both a clinical assessment and direct observation, of a child's emotional, social, behavioral and developmental functioning.
- **Multidisciplinary** - An evaluation and assessment process involving activities by one or more qualified professionals from two or more disciplines working with the family and primary service coordinator to identify the needs of the child and family.
- **Neglect** – Any act or omission where a child is deprived of or allowed to be deprived of necessary supervision, food, clothing, shelter or medical treatment or a child is permitted to live in an environment when such deprivation or environment causes the child's physical, mental or emotional health to be significantly impaired or to be in danger of being significantly impaired.
- **Screening** - A brief assessment procedure designed to identify infants and toddlers who are in need of more intensive diagnostic or assessment activities.
- **Substantiated Findings** – Findings that have been verified vs. those that are suspected.

V. GENERAL ROLES AND RESPONSIBILITIES

A. The Department of Health agrees to:

1. Work cooperatively with DCF to meet the needs of children identified and eligible for services identified in this Agreement.
2. Meet as necessary with DCF, but at a minimum annually, to oversee the performance under this agreement, track the development and progress of local implementation plans, and address any issues of mutual concern.
3. Educate and train personnel, including DCF protective investigators and Sheriff's Office protective investigators (in those counties where the Sheriff's Office handles protective investigation duties) on the following: 11/30/2007
 - ☐ best practices and appropriate procedures for referrals and other services covered by this agreement
 - ☐ key indicators for concern that a child may have a developmental delay
4. Discuss in advance any policy or operational changes that may affect the services provided or the population being served under this agreement.
5. Assist with development of a model written agreement for use at the local level that addresses roles and responsibilities for the referral of children under the age of three involved in substantiated cases of abuse or neglect to the local Early Steps.
6. Encourage written agreements at the local level which address each agency's roles and responsibilities related to services across programs and the referral of children under the age of three who are involved in substantiated cases of child abuse or neglect to early intervention services under IDEA Part C.

B. The Department of Children and Families agrees to:

1. Work cooperatively with the DOH to meet the needs of children identified and eligible for services identified in the Agreement.
2. Meet as necessary with DOH, but at a minimum annually, to oversee the performance under this agreement, monitor local implementation plans, and address any issues of mutual concern.
3. Educate and train personnel, including local Early Steps staff, on the best practices and appropriate procedures for working with children and family members in circumstances of child abuse and neglect, as well as the types of services provided by Community Based Care Lead Agency in such situations.
4. Discuss in advance any policy or operational changes that may affect the services provided or the population being served under this agreement.
5. Assist with development of a model written agreement for use at the local level that addresses roles and responsibilities for the referral of children under the age of three involved in substantiated cases of abuse or neglect to the local Early Steps.
6. Encourage written agreements at the local level which address each agency's roles and responsibilities related to services across programs and the referral of children under the age of three who are involved in 11/30/2007 4 substantiated cases of child abuse or neglect to early intervention services under IDEA Part C.

C. To ensure this agreement is implemented, local DCF personnel, sheriff's offices, Community Based Care lead agencies and Local Early Steps shall:

1. Meet on a regular basis to develop and implement protocols
2. Review local plans and progress,
3. Resolve disagreements; and
4. Make recommendations to DOH and DCF agency headquarters on procedures that may increase the efficiency of the referral process.

VI. REFERRAL TO EARLY STEPS

A. Children from birth to thirty-six months who have been determined to be victims of “substantiated cases of child abuse or neglect”, as defined by the Florida Office of Family Safety will be referred to Early Steps according to the following criteria:

1. Children who will remain in their parents’ or legal guardian’s home **without referral to a Community Based Care lead agency for services** will be referred to Early Steps by the Protective Investigator handling that case. This will be done by completion of the referral form CF FSP 5322- CAPTA REFERRAL FOR EARLY STEPS, within 48 hours of the abuse or neglect being verified. The completed form will be delivered to the local Early Steps via facsimile, electronic mail that is encrypted or protected by a password or as determined by local working agreement between the local Early Steps and Sheriff’s office, or DCF protective investigations office.

2. Children who will remain in their parents’ or legal guardian’s home and are **referred to a CBC lead agency for services**, may also be referred to Early Steps by the CBC lead agency child welfare case worker if the following criteria is met: A referral to Early Steps will occur during the child welfare case plan development process when there is an indication that the child may have an established condition or developmental delay. This will be accomplished by completion of the referral form CF FSP 5322- CAPTA REFERRAL FOR EARLY STEPS, within 48 hours of the child’s established condition or possible developmental delay being identified. The form must include the reason for referral. The form will be delivered to the local Early Steps via facsimile, electronic mail that is encrypted or protected by a password, or as determined by local working agreement between the local Early Steps and the CBC lead agency. The CBC lead agency will follow up to determine if the child has been found eligible for Part C services and will support the participation of 11/30/2007 5 eligible children’s families in Early Steps This support may include the following:

- Assistance with transportation if necessary
- Provision of written information about Early Steps
- Follow-up with the family and encouragement about child’s participation in Early Steps.

3. Children who are being **placed into shelter care for referral to a lead agency for out-of-home care placement** will receive an initial assessment during the child welfare case plan development process and may be referred to Early Steps in accordance with the following criteria :

a. Children who **are not referred** for a Medicaid Comprehensive Behavioral Health Assessment will be referred to Early Steps by the child welfare case worker during the case plan development process for the child. The referral form, CF FSP 5322- CAPTA REFERRAL FOR EARLY STEPS, will be completed by the child welfare case worker, who will also ensure the child’s case plan reflects the referral. When completed, the referral form will be delivered to the local Early Steps via facsimile, electronic mail that is encrypted or protected by a password, or as determined by local working agreement between the Early Steps program and the lead agency.

b. Children who **are referred** for a Medicaid Comprehensive Behavioral Health Assessment, will also be referred to Early Steps by the CBC child welfare case worker if the child’s comprehensive behavioral health assessment flags the child as potentially having a developmental delay or an established condition. The Early Steps referral will be reflected in the child’s case plan. Once completed, the form will be delivered to the local Early Steps via facsimile, electronic mail or as determined by local working agreement between the Early Steps program and the CBC. The Early Steps referral form **must** be accompanied by the Medicaid Comprehensive Behavioral Health Assessment that indicates the child shows indications of possible developmental delay or has an established condition.

4.. The local Early Steps will screen or evaluate all children referred by the DCF or its contracted agencies as indicated in VI.A. 1-3 above, in accordance with Early Steps policy. When a child is referred to Early Steps from a child welfare case worker, the information on the outcome of the child’s screening or evaluation and any

recommended services on the child's individualized family support plan will be forwarded by the Early Steps service coordinator to the lead agency for consideration in development of the child's case plan. Local 11/30/2007 6 agreements between the local Early Steps and the lead agency will establish how this information exchange will take place.

VII. INFORMATION SHARING AND RECORDS

Each agency will protect the rights of children with disabilities and their families with respect to records created, maintained, and used by public institutions and contract providers within the state of Florida. It is the intent of this Agreement to ensure that applicable laws and regulations for these rights shall be strictly followed. Necessary information concerning children, including information received from arrest, treatment/service, and the Florida Abuse Hotline Information System as well as data necessary to measure program outcomes, will be shared between agencies in accordance with applicable state and federal laws. Nonspecific child data on number of referrals and the outcome of referrals will be shared for federal and planning purposes. Outcome information may be limited to number of children determined eligible or noneligible. Each agency shall ensure that its contracts for services affected by this Agreement shall include provisions for confidentiality of records and information.

VIII. INTERAGENCY DISPUTE PROCESS

The parties to this agreement will resolve any complaints or grievances as follows: Resolution of the conflicting issues will occur at the lowest level possible.

- A. The grieving agency shall provide the complaint or grievance in writing and identify the conflict; proposed action to be taken and by whom; and a summary of factual, legal and policy grounds.
- B. The receiving agency shall provide a written response, which includes proposed solutions to the dispute, within forty-five (45) calendar days of receiving the notice of conflict.
- C. Upon resolution of the conflict, a joint written statement indicating the resolution will be developed. The statement will be disseminated by a representative from each agency and be binding upon the agencies involved.
- D. Should additional action be required to resolve a conflict, a report from both agencies will be submitted to the appropriate parties who signed the agreement representing their agency. Such parties shall request an administrative hearing consistent with the procedures in 120.57(1) F.S., the Administrative Procedures Act. Decisions made as a result of such hearing will be final and binding upon the agencies involved. Until final resolution of a dispute, each of the parties to this agreement shall respect the policies and procedures of one another. 11/30/2007 7

IX. ALLOCATION OF RESOURCES

The agencies agree to communicate and, where possible, coordinate services provided under this Agreement to ensure the effective and efficient use of funds and agree to maximize all available funding sources. Funds used for services by each agency pursuant to this Agreement shall not supplant other existing treatment funding.

X. ADMINISTRATIVE PROCEDURES

A. Timelines:

This Agreement shall become effective upon full execution and shall automatically renew on an annual basis unless terminated by either party. This Agreement will be reviewed annually, and either party may request an amendment. Any proposed amendments or modifications shall be submitted in writing by either party at least thirty (30) days prior to formal discussion or negotiation in the issue. Any amendments shall become effective only if agreed to in writing observing all the formalities of this Agreement. Either party may terminate this Agreement without cause and for its convenience by giving thirty (30) calendar days' written notice.

B. Notice Provision:

When either party desires to give notice to the other, such notice must be in writing, sent by U.S. Mail with postage prepaid, addressed to the party for whom it is intended at the place last specified. The place for giving notice shall remain such until it is changed by written notice in compliance with the provision of the paragraph. To DOH: State Surgeon General Ana M. Viamonte Ros, M.D., M.P.H.

Florida Department of Health

2585 Prather Building

Tallahassee, FL 32399-1707

To DCF: Robert A. Butterworth, Secretary

Florida Department of Children & Families

1317 Winewood Blvd., Bldg, 1, Room 202

Tallahassee, FL 32399-0700

C. Authority:

Each person signing this Agreement on behalf of either party individually warrants that he or she has full legal power to execute this Agreement on behalf of the party for whom he or she is signing, and to bind and obligate such party with respect to all provisions contained in this Agreement. Each agency specifies by position the persons who have primary responsibility for implementing and signing this Agreement. 11/30/2007 8

APPENDIX F STD Protocols

Appendix F includes the following documents:

- **CPT STD Technical Assistance Guideline (TAG) 39:** provides guidance on the utilization of prophylactic STD medications and procedures for specimen collection.
- **CPT STD Prophylactic Medication Compliance Checklist:** contains the State and Federal requirements that each CPT must achieve prior to implementing this service. This checklist must be signed and dated by CPT staff. Other components included in the checklist are: CPT staff responsibilities, CPT staff that will be receiving STD medications and the facility address where medications will be delivered.
- **CPT STD Medical Provider Profile:** The profile must be completed by the CPT medical director and any CPT medical providers that will be ordering medications from the DOH pharmacy. The DOH pharmacy staff will utilize the profile to enter staff in the FDOH pharmacy secure online medication ordering system. This will give CPT staff authority to order the medications.
- **CPT STD Inventory Checklist:** This is the document that CPT staff must keep updated. It is an internal document to track the inventory of medications located at the CPT and must be kept for (6) years.
- **Prescription Return Form:** The form is located on the following DOH Central Pharmacy website: and is to be utilized when returning outdated STD medications.
<http://dohiws/Divisions/Pharmacy/Forms/RxReturnForm.pdf> . Address for the Central Pharmacy is: 116A Hamilton Park Dr. Tallahassee, Florida 32304.
- **Directory for FDOH Laboratories:** http://www.doh.state.fl.us/lab/addpages/BOL_Contacts.html
- **DH1847 Form: Laboratory Request:**
http://www.doh.state.fl.us/lab/PDF_Files/DOH_Form_DH1847_1009.pdf
- **CPT STD Instructions for specimen collection and shipping of specimens:**
 - APTIMA® Unisex Swab Specimen Collection Kit for Endocervical and Male Urethral Swab Specimens
 - APTIMA® Urine Specimen Collection Kit for Male and Female Urine Specimens
 - COLLECTION AND SHIPPING OF SPECIMENS FOR HERPES SIMPLEX VIRUS (HSV) EXAMINATION

CHILD PROTECTION TEAM (CPT)
PROVISION OF PROPHYLACTIC MEDICATION AND COLLECTION OF SPECIMENS FOR SEXUALLY TRANSMITTED DISEASE (STD)

Provision of prophylactic medications in the prevention of STD for sexual assault in adolescents and pre-pubertal children:

Under the Health Resources and Services Administration (HRSA) Pharmacy Affairs and 340B drug pricing program <http://www.hrsa.gov/opa/introduction.htm> in coordination with the Florida Department of Health (FDOH) STD program office and FDOH Pharmacy, prophylactic STD medications will be provided to the CPTs. The STD prophylactic medications will be administered to CPT clients who have been determined to be at risk for contracting a STD. The recommended treatment guidelines are located in: **The TECHNICAL ASSISTANCE GUIDELINE: STD-39 (TAG)** “Technical Assistance for the Provision of Unit of Use of Re-packaged Prophylactic Medicines to Child Protection Team Provider Sites in the Prevention of Sexually Transmitted Diseases (STDs) for Sexual Assault in Adolescents and Pre-pubertal Children”, which is located in Appendix F.

The TECHNICAL ASSISTANCE GUIDELINE: STD-39 (TAG) “Technical Assistance for the Provision of Unit of Use of Re-packaged Prophylactic Medicines to Child Protection Team Provider Sites in the Prevention of Sexually Transmitted Diseases (STDs) for Sexual Assault in Adolescents and Pre-pubertal Children”, (which is located in A.)).

Guidelines include the following recommendations:

Adolescents:

- Adolescents should be prophylactically treated for STDs if they have had acute sexual activity within the previous 60 days.
- Adolescents should not be prophylactically treated for STDs when:
 - History of sexual activity occurs in the remote past (more than 60 days ago), without current sexual activity or discharge
 - No self-report or evidence of sexual activity

Pre-pubertal Children:

- Pre-pubertal children are at a very low risk to acquire an STD. The Centers for Disease Control and Prevention (CDC) and the AAP do not recommend routine prophylaxis for this age group in most instances. They recommend close follow up to determine if an infection is acquired. Nevertheless, children this age are sometimes infected, sometimes have asymptomatic infections, and follow up is not always assured.

Consider prophylactic treatment with the following:

- Acute sexual activity (oral, vaginal, anal) by an unknown person (e.g., stranger) and concern about possible infection
- Sex with a person known to have an STD
- Significant concern about and/or request for prophylactic antibiotic coverage following sexual contact

Pre-pubertal children do not need treatment if:

- Sexual activity occurred with the same known person and there is no discharge or other sign of infection

- Sexual activity occurred with an unknown person, it is more than 14 days later, and there is no discharge or signs of infection

Medication Regimen:

Administer in clinic:

Azithromycin (Zithromax®) 1 gram x 1 (tablet)

Prescribe Plan B – (if mature enough to have menstrual periods and female)

Guardian to administer four hours later:

Cefixime (Suprax®) 400 mg x 1 (tablet)

Guardian to administer eight hours later:

Metronidazole (Flagyl®) 2 grams x 1 (four 500mg tablets)

The purpose of spacing the medications is to decrease the likelihood of vomiting and other adverse effects.

340B Drug Pricing Program:

“The 340B Drug Pricing Program resulted from enactment of Public Law 102-585, the Veterans Health Care Act of 1992, which is codified as Section 340B of the Public Health Service Act. The 340B Drug Discount Program is managed by the Health Resources and Services Administration (HRSA) Office of Pharmacy Affairs (OPA). 340B limits the cost of covered outpatient drugs to certain federal grantees, federally-qualified health center look-alikes and qualified disproportionate share hospitals. Participation in the Program results in significant savings estimated to be 20% to 50% on the cost of pharmaceuticals for safety-net providers. The purpose of the 340B Program is to enable these entities to stretch scarce federal resources, reaching more eligible patients and providing more comprehensive services.”

Who is Eligible for the 340B Discount?

- Federally-qualified health center
- Family planning project
- Entity receiving a grant under subpart II of part C of Title XXVI of the Ryan White Care Act
- A state-operated AIDS Drug Assistance Program
- A black lung clinic
- A comprehensive hemophilia diagnostic treatment center
- A Native Hawaiian Health Center
- An Urban Indian organization
- Any entity receiving assistance under title XXVI of Social Security Act
- A disproportionate share hospital
- An entity receiving funds under section 318, relating to the treatment of sexually transmitted diseases or section 317, relating to the treatment of tuberculosis, through a State or unit of local government, but only if the entity is certified by the Secretary

It is under the STD program that CPT will receive medications.

How the CPT providers be eligible to receive 340B priced medications

- In the cases where sexual abuse is suspected and prophylactic treatment is appropriate, these clients are considered STD clients and are managed according to STD program treatment guidelines.

- Therefore, these clients are eligible for the discounted medications through the 340B Drug Pricing Program.
- The Florida STD Program is providing these medications *free of charge* to CPT providers that complete their registration through the compliance check-list.

Child Protection Team (CPT) Sexually Transmitted Disease (STD) Prophylactic Medication Compliance Checklist

This form must be completed and returned to CPT central office staff prior to the CPT receiving authorization to order STD medications from FDOH pharmacy. The following requirements are included in the compliance checklist:

- CPT has a locked cabinet to store the STD prophylactic medications
- STD prophylactic medications are stored separately from any other medications
- CPT has a Log Book to sign medications in and out and record prescription information (**CPT STD Prophylactic Inventory Log, which is located in Appendix F**)
- Method to record patient information (CPTIS)
- Protocols for specimen collection (**located in Appendix F**)
- Protocol for shipping specimens (**Instructions for shipping specimens to the DOH State Laboratory located in Appendix F**)
- CPT medical providers add facility address to their license registration with MQA as additional place of practice (**MQA staff will add the facility address to medical provider profile**)
- Policy for the disposal of expired medications (**Disposal Form located in Appendix F**)

Also included on the Compliance Checklist are the CPT staff responsibilities:

- Sending completed medical provider profile, including address of CPT, to designated DOH headquarters staff. The facility address must be added the as an additional place of practice to the MQA medical provider profile. (**MQA staff will add the facility address to medical provider profile**)
- Maintaining the CPT STD Prophylactic Inventory Log
- Ordering STD prophylactic medications from the DOH State Pharmacy
- Ordering laboratory supplies from the DOH State Laboratory
- Adhering to procedures for collecting, packaging, and shipping specimens to the DOH State Laboratory
- Entering data into CPTIS on all patients receiving STD prophylactic medications
- Adhering to procedures for checking medication expiration dates and returning expired medications to the DOH pharmacy

A. Technical Assistance for the Provision of Unit of Use of Re-packaged Prophylactic Medicines to Child Protection Team Provider Sites in the Prevention of Sexually Transmitted Diseases (STDs) for Sexual Assault in Adolescents and Pre-pubertal Children

I. TITLE: Technical Assistance for the Provision of Unit of Use of Re-packaged Prophylactic Medicines to Child Protection Team Provider Sites in the Prevention of Sexually Transmitted Diseases (STDs) for Sexual Assault in Adolescents and Pre-pubertal Children

II. TYPE OF STANDARD: Disease Management/Service

III. OUTCOME: Successful prevention of STDs and their complications in children and adolescents that are victims of sexual assault

IV. PERSONNEL: M.D.s, D.O.s, A.R.N.P.s, and P.A.s within the constraints of their practice acts and protocols

V. COMPETENCIES: Healthcare professionals should have demonstrated knowledge, judgment, and performance of the responsibilities related to the medical management of sexual assault in adolescents and pre-pubertal children. Professional personnel records should have documentation of appropriate training for their individual practice acts.

VI. AREAS OF RESPONSIBILITY:

1. ASSESSMENT

A. Subjective Factors:

1. Medical and Social History – A developmentally appropriate history should be obtained by the pediatrician before a medical examination is performed.

a. Investigative interviews should be performed by social services and/or a law enforcement agency; however, this does not preclude the physician from obtaining a detailed pediatric history and review of systems to include:

- i. Medical history
- ii. Past incidents of abuse or suspicious injuries
- iii. Menstrual history

b. History of the absence of penile-vaginal penetration, penile-oral, or penile anal penetration is not always reliable. Clinical judgment must be used.

B. Objective Factors:

1. Developmentally appropriate assent should be obtained from the child victim before examination, specimen collection, and treatment administration.

2. Obtain all appropriate specimens to test for STDs before giving prophylactic medications. For example:

- a. Nucleic Acid Amplification Test (NAAT) for *Chlamydia trachomatis* and *Neisseria gonorrhoeae* (urine, urethral and/or cervical swabs, anal swabs are acceptable options when submitted to state laboratory)
- b. Swabs to culture for herpes simplex virus and *Chlamydia trachomatis*

3. Test for pregnancy in females who are sexually mature enough that fertility is possible

4. Determination that the child has no allergies to the medications (Note: the recommended treatment options rarely cause allergic reactions.)

5. HIV prophylaxis – use local guidelines for prophylaxis or refer to HIV center

6. HBV and HPV vaccines should be considered for patients who meet American Academy of Pediatrics (AAP) guidelines.

2. TREATMENT

A. Adolescents:

1. Adolescents should be prophylactically treated for STDs if they have had acute sexual activity within the previous 60 days.

2. Adolescents should not be prophylactically treated for STDs when:

- a. History of sexual activity occurs in the remote past (more than 60 days ago), without current sexual activity or discharge (Note: this may be an opportunity for screening for chlamydia.)
- b. No self-report or evidence of sexual activity

B. Pre-pubertal Children:

1. Pre-pubertal children are at a very low risk to acquire an STD. The Centers for Disease Control and Prevention (CDC) and the AAP do not recommend routine prophylaxis for this age group in most instances. They recommend close follow up to determine if an infection is acquired. Nevertheless, children this age are sometimes infected, sometimes have asymptomatic infections, and follow up is not always assured.

a. Consider prophylactic treatment with the following:

- i. Acute sexual activity (oral, vaginal, anal) by an unknown person (e.g., stranger) and concern about possible infection
- ii. Sex with a person known to have an STD
- iii. Significant concern about and/or request for prophylactic antibiotic coverage following sexual contact

2. Pre-pubertal children do not need treatment if:

- a. Sexual activity occurred with the same known person and there is no discharge or other sign of infection
- b. Sexual activity occurred with an unknown person, it is more than 14 days later, and there is no discharge or signs of infection

C. Medication Regimen:

1. Administer in clinic:

- a. Azithromycin (Zithromax®) 1 gram x 1 (tablet)
- b. Prescribe Plan B – (if mature enough to have menstrual periods and female)

2. Guardian to administer four hours later:

- a. Cefixime (Suprax®) 400 mg x 1 (tablet)

3. Guardian to administer eight hours later:

- a. Metronidazole (Flagyl®) 2 grams x 1 (four 500mg tablets)

4. The purpose of spacing the medications is to decrease the likelihood of vomiting and other adverse effects.

D. Examples:

1. A 14-year-old female is seen at noon. She was at a party the night before, drank some beer, and ended up in bed with a 16-year-old boy. She reported having penile-vaginal intercourse without a condom. This was her first sexual encounter.

a. Obtain assent for examination. Collect specimens for STD testing, pregnancy testing, collection of clothing, evidence swabs (decreased utility if she showered or bathed).

b. Obtain assent for prophylactic medications and determine if there are any medication allergies. (The recommended treatment options rarely cause allergic reactions.)

c. Dispense re-packaged prophylaxis medications:

- i. Administer azithromycin immediately in the clinic
- ii. Prescribe Plan B
- iii. Four hours later, cefixime administered by guardian
- iv. Eight hours later, metronidazole administered by guardian

2. A 15-year-old male arrives at the CPT at 1:00 am. He reports he was spending the night with his best friend. He said his friend's mom and her boyfriend let them drink a beer with them before bed. After the adults went to bed, the boys drank six beers each. The alleged victim said he remembers throwing up and then fell asleep on the bathroom floor. When he woke up, the mom's boyfriend was masturbating over him. He complains of pain in his rectal area and blood on the toilet paper after he defecated.

- a. Obtain assent for examination and signed consent form.
- b. Obtain rectal swab for gonorrhea and chlamydia. Also, collect clothing and evidence swabs.
 - i. Collect blood for HIV and RPR.
- c. Dispense repackaged prophylaxis medications
 - i. Administer azithromycin immediately in the clinic
 - ii. Four hours later, cefixime administered by guardian
 - iii. Eight hours later, metronidazole administered by guardian
- d. Refer child for follow-up specimen collection to test for HIV and syphilis.

3. EMERGENCY: Refer to appropriate provider(s) for the presenting complication(s).

4. DOCUMENTATION: Document on appropriate state forms:

- A. CPT STD medical record
- B. CPT STD Prophylactic Inventory Log
- C. DOH Form 1847, Bureau of Laboratory Request Form

VII. SUPPORTIVE DATA:

- 1. U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention. *Morbidity and Mortality Weekly Report: Sexually Transmitted Diseases Treatment Guidelines 2006, Sexual Assault and STDs*, (August 2006), Atlanta, GA, available at: <http://www.cdc.gov/std/treatment/2006/sexual-assault.htm>
- 2. Kellogg N, American Academy of Pediatrics Committee on Child Abuse and Neglect. *The evaluation of sexual abuse in children*. Pediatrics 2005;116:506–12, available at: <http://pediatrics.aappublications.org/cgi/reprint/116/2/506?maxtoshow=&hits=10&RESULTFORMAT=&fulltext=evaluation+of+sexual+abuse+in+children&searchid=1&FIRSTINDEX=0&sortspec=relevance&resourcetype=HWCIT>
- 3. Health Resources and Services Administration (HRSA) Pharmacy Affairs and 340B Drug Pricing Program, available at: <http://www.hrsa.gov/opa/introduction.htm>
- 4. Florida Department of Health, Child Protection Team Program Policy and Procedure Handbook, (August 2009 or current version), available at: http://www.cms-kids.com/families/child_protection_safety/child_protection_teams.html
- 5. DOH Collection and Shipping of Specimens for Herpes Simplex Virus Examination guidelines. See Attachment 1.
- 6. Aptimar Urine Specimen Collection Kit for Males and Female Urines Specimens Guidelines. See Attachment 2.
- 7. Aptima Unisex Swab Specimen Collection Kit for Endocervical and Male Urethral Swab Specimens. See Attachment 3.
- 8. Sections 384, 391, 458, and 459, Florida Statutes, available at: <http://www.leg.state.fl.us/Statutes/index.cfm?Mode=View%20Statutes&Submenu=1&Tab=statutes&CFID=31117601&CFTOKEN=67521185>
- 9. Chapter 64D-3, Florida Administrative Code, available at: <https://www.flrules.org/gateway/ChapterHome.asp?Chapter=64D-3>

B. CHILD PROTECTION TEAM (CPT) SEXUALLY TRANSMITTED DISEASE (STD)
PROPHYLACTIC MEDICATION COMPLIANCE CHECKLIST
CPT: _____

State and Federal Requirement	Requirement has been met Date/Signature
CPT has a locked cabinet to store the STD prophylactic medications	
STD prophylactic medications are stored separately from any other medications	
CPT has a Log Book to sign medications in and out and record prescription information. CPT STD Prophylactic Inventory Log is located in the CPT Handbook)	
Method to record patient information (CPTIS)	
Protocols for specimen collection (located in the CPT Handbook)	
Protocol for shipping specimens (Instructions for shipping specimens to the DOH State Laboratory located in the CPT Handbook)	
CPT medical providers add facility address to their license registration with MQA as additional place of practice (MQA staff will add the facility address to medical provider profile)	
Policy for the disposal of expired medications (Disposal policy and disposal form located in the CPT Handbook)	

CPT staff responsibilities:

- Sending completed medical provider profile, including address of CPT, to designated DOH headquarters staff. The facility address must be added the as an additional place of practice to the MQA medical provider profile. **MQA staff will add the facility address to medical provider profile**
- Maintaining the CPT STD Prophylactic Inventory Log
- Ordering STD prophylactic medications from the DOH State Pharmacy
- Ordering laboratory supplies from the DOH State Laboratory
- Adhering to procedures for collecting, packaging, and shipping specimens to the DOH State Laboratory
- Entering data into CPTIS on all patients receiving STD prophylactic medications
- Adhering to procedures for checking medication expiration dates and returning expired medications to the DOH pharmacy

CPT staff that will be signing for receipt of STD prophylactic medications:

Staff Name	Profession	License Number

Facility address (location medications will be mailed to):

C. CPT STD Prophylactic Medications Medical Provider Profile

This form is to be completed and updated as appropriate by each medical professional that will ordering and receiving STD Prophylactic medications. The completed form will be sent to CMS central office staff to be utilized by FDOH pharmacy staff to enter CPT staff into the FDOH pharmacy secure online medication ordering system. The following information is collected on the medical provider profile form.

User Information :

First Name :

Last Name :

Phone Number:

Provider DEA Permit Number :

Florida License Number :

Email:

DOH Email:

Ship To Facility:

Facility Name :

Address :

City :

State :

Zip :

County:

STD Prophylactic Inventory Log
CPT Location: _____
Month/Year: _____

Medication Description	Pkg Size	Beginning Inventory	Additional Received this period	Dispensed Medication	Quantity in Stock	Ending Inventory	Difference	National Drug Code *	Expiration Date *
Azithromycin (Zithromax) 1 gram									
Cefixine (Suprax) 400 mg									
Metronidazole (Flagyl) 2 grams									
Pregnancy Test									

Log sheet must be maintained for (6) years
***This information is found on the medication label**

COLLECTION AND SHIPPING OF SPECIMENS FOR HERPES SIMPLEX VIRUS (HSV) EXAMINATION*

Properly collected specimens for HSV isolation is one of the most important factors in successful laboratory diagnosis. Specimens should be collected as soon as possible after onset and transported immediately to the laboratory.

Specimen Collection:

1. Using a dry, sterile polyester ("Dacron") swab with a plastic shaft collect vesicular fluid, cervical and/or vaginal secretions. Place swab in viral transport medium (VTM). **DO NOT USE SWABS WITH WOODEN SHAFT.**
2. Using a second dry, sterile swab, collect vesicular fluid and cells from the base of the lesions. Make a dime-sized circle with the swab on a glass slide; label the end of the slide with the patient name and collection site. Allow the slide to air dry.

AIR DRY!

DO NOT SPRAY!

DO NOT FIX!

Place slide in

M. Jones
Vaginal

**protective
slide container**

3. Complete laboratory history form DH1847 and include onset date, collection date(s), specific specimen collection sites, etc...
4. Place slide and swab in transport medium into a Styrofoam shipping container. Use 1-2 cold packs to maintain the temperature during transit. Ship in the most expedient manner, preferably overnight delivery.
5. Ship to: Virus Unit

Florida Department of Health-Bureau of Laboratories
1217 Pearl Street
Jacksonville, FL 32202

For additional information call: (904) 791-1540

*Adapted from: Laboratory Methods for Diagnosis of Herpes virus Infections
USPHA, Centers for Disease Control and Prevention, Atlanta, GA
December, 1979

APTIMA® Urine Specimen Collection Kit for Male and Female Urine Specimens

1 501936EN Rev. A

For *in vitro* diagnostic use.

Intended Use

The APTIMA Urine Specimen Collection Kit for Male and Female Urine Specimens is for use with APTIMA assays. The APTIMA Urine Specimen Collection Kit is intended to be used for the collection and transport of male or female urine specimens.

Materials Provided

50 APTIMA Urine Specimen Collection Kits for Male and Female Urine Specimens (Cat. No. 301040)

Each kit contains: **Component**

Quantity

Description

Pipette

1

Disposable transfer pipette.

Specimen transport tube

1

Tube containing 2.0 mL APTIMA urine transport medium.

Warnings and Precautions

A. Do not apply the transport medium directly to skin or mucous membranes or take internally.

Kit Storage Requirements

Store collection kit at room temperature (15°C to 30°C).

Urine Specimen Performance

The assay performance characteristics of the male and female urine specimens are provided in the appropriate APTIMA assay package insert. The APTIMA assay package inserts may be referenced online at www.gen-probe.com. The table below identifies the acceptable specimen types for each of the APTIMA assays.

APTIMA Assay for

Female Urine Specimens

Male Urine Specimens

Chlamydia trachomatis

Chlamydia trachomatis and *Neisseria gonorrhoeae* (Aptima Combo 2 Assay)

Neisseria gonorrhoeae

Yes

Yes

Specimen Collection and Handling

1. The patient should not have urinated for at least 1 hour prior to specimen collection.
2. Direct patient to provide a first-catch urine (approximately 20 to 30 mL of the initial urine stream) into a urine collection cup free of any preservatives. Collection of larger volumes of urine may result in rRNA target dilution that may reduce test sensitivity. Female patients should not cleanse the labial area prior to providing the specimen.
3. Remove the cap and transfer 2 mL of urine into the urine specimen transport tube using the disposable pipette provided. The correct volume of urine has been added when the fluid level is between the black fill lines on the urine specimen transport tube label.
4. Re-cap the urine specimen transport tube tightly. This is now known as the processed urine specimen.

Specimen Transport and Storage

After collection, transport the processed urine specimens in the APTIMA urine specimen transport tube at 2°C to 30°C and store at 2°C to 30°C until tested. Processed urine specimens should be assayed with the APTIMA assay within 30 days of collection. If longer storage is needed, refer to the appropriate APTIMA assay package insert.

Urine samples that are still in the primary collection container must be transported to the lab at 2°C to 30°C. Transfer the urine sample into the APTIMA urine specimen transport tube within 24 hours of collection. Store at 2°C to 30°C and test within 30 days of collection.

Note: Specimens should be transported in compliance with Federal regulations for transport of etiological agents. Please refer to HHS Publication No. CDC 93-8395 or latest revision.

Limitations

A. Use this collection kit only with the APTIMA assays. Performance has not been established with other products.

Gen-Probe Incorporated

San Diego, CA 92121 USA

U.S. and international contact information

Customer Service: +1 858 410 8002

customerservice@gen-probe.com

Technical Support: +1 858 410 8511

technicalsupport@gen-probe.com

Toll-free from U.S. and Canada

Customer Service: +1 800 523 5001

Technical Support: +1 888 484 4747

www.gen-probe.com

MLT Research Ltd

Attn. Dr Andrew Rutter

5 Chiltern Close

Cardiff

CF14 5DL

United Kingdom

© 2001-2010 Gen-Probe Incorporated

501936EN Rev. A

2009-11

APTIMA® Unisex Swab Specimen Collection Kit for Endocervical and Male Urethral Swab Specimens

1 501935EN Rev. A

For *in vitro* diagnostic use.

Intended Use

The APTIMA Unisex Swab Specimen Collection Kit for Female Endocervical and Male Urethral Swab Specimens is for use with APTIMA assays. The APTIMA Unisex Swab Specimen Collection Kit is intended to be used for the collection of female endocervical or male urethral swab specimens.

Materials Provided

50 APTIMA Unisex Swab Specimen Collection Kits for Endocervical and Male Urethral Swab Specimens (Cat. No. 301041)

Each kit contains:

Component	Quantity	Description
Unisex collection swab*	1	Swab for endocervical or male urethral swab specimens.
Cleaning swab*	1	Female cleaning swab.
Transport tube	1	Tube containing APTIMA swab transport medium (2.9 mL).

Warnings and Precautions

A. Do not apply the transport medium directly to skin or mucous membranes or take internally.

Kit Storage Requirements

Store collection kit at room temperature (15°C to 30°C).

Swab Specimen Performance

The assay performance characteristics of the female endocervical and male urethral swab specimens are provided in the appropriate APTIMA assay package insert. The APTIMA assay package inserts may be referenced online at www.gen-probe.com. The table below identifies the acceptable specimen types for each of the APTIMA assays.

APTIMA Assay for Female Urine Specimens

Male Urine Specimens

Chlamydia trachomatis

Chlamydia trachomatis and *Neisseria gonorrhoeae* (Aptima Combo 2 Assay)

Neisseria gonorrhoeae

Yes

Yes

Specimen Collection and Handling

A. Endocervical swab specimens

1. Remove excess mucus from the cervical os and surrounding mucosa using the cleaning swab (white shaft swab in the package with red printing). Discard this swab.

Note: To remove excess mucus from the cervical os, a large-tipped swab (not provided) may be used.

2. Insert the specimen collection swab (blue shaft swab in the package with the green printing) into the endocervical canal.

3. Gently rotate the swab clockwise for 10 to 30 seconds in the endocervical canal to ensure adequate sampling.
4. Withdraw the swab carefully; avoid any contact with the vaginal mucosa.
5. Remove the cap from the swab specimen transport tube and immediately place the specimen collection swab into the transport tube.
6. Carefully break the swab shaft against the side of the tube at the scoreline and discard the top portion of the
7. Re-cap the swab specimen transport tube tightly.

B. Male urethral swab specimens

1. The patient should not have urinated for at least 1 hour prior to sample collection.
2. Insert the specimen collection swab (blue shaft swab in the package with the green printing) 2 to 4 cm into the urethra.
3. Gently rotate the swab clockwise for 2 to 3 seconds in the urethra to ensure adequate sampling.
4. Withdraw the swab carefully.
5. Remove the cap from the swab specimen transport tube and immediately place the specimen collection swab into the transport tube.
6. Carefully break the swab shaft against the side of the tube at the scoreline and discard the top portion of the swab shaft; use care to avoid splashing of contents.
7. Re-cap the swab specimen transport tube tightly.

Specimen Transport and Storage

After collection, transport and store the swab in the swab specimen transport tube at 2°C to 30°C until tested. Specimens must be assayed with the APTIMA assays within 60 days of collection. If longer storage is needed, refer to the appropriate APTIMA assay package insert.

Note: Specimens should be transported in compliance with Federal regulations for transport of etiological agents. Please refer to HHS Publication No. CDC 93-8395 or latest revision.

Limitations

A. Use this collection kit only with the APTIMA assays. Performance has not been established with other products.

Gen-Probe Incorporated
San Diego, CA 92121 USA

U.S. and international contact information
Customer Service: +1 858 410 8002
customerservice@gen-probe.com
Technical Support: +1 858 410 8511
technicalsupport@gen-probe.com

Process for the online ordering of STD Medications from DOH Central Pharmacy;

FDOH central pharmacy staff will enter information from the CPT medical profile form (Appendix F) into the FDOH pharmacy secure online medication ordering system. After the CPT medical profile has been entered they will receive the following email:

"Welcome to the Pharmaceutical Forms System. To access the system, go to:
<http://www.fdohcentralpharmacy.com/login.aspx>. Enter your User ID and your password (which will be provided in the email received from the DOH pharmacy), reset the password and click 'Login'." After logging in the following screen will appear:

Step 1:

Click on Repack Pharmaceutical request (blue box)

The screenshot shows the 'Pharmaceutical Forms System' login page. At the top left is the 'FLORIDA DEPARTMENT OF HEALTH' logo. Below it, the title 'Pharmaceutical Forms System' is displayed. On the right, there is a 'flor' logo and a user login area with 'In' and 'Hr' labels. A blue button labeled 'Repack Pharmaceutical Request' is prominently displayed. Below this button, a red warning message states: 'If you have not submitted your request within 72 hours, it will be deleted.' The main content area is titled 'Forms' and contains a search bar with a dropdown menu set to 'By Request Number' and a 'Search' button. To the right of the search bar are radio buttons for 'Form' (All, Repack) and 'Status' (All, In Progress, New Request, Under Review, Shipped, Approved). Below these are several tabs: 'Form Requestor', 'Form Type', 'Facility', 'Status', 'Request Number', 'Requested By', 'Reviewed By', 'Shipped By', and 'Shipment Information'. At the bottom of the search area, it says 'Page 1 of 0' and 'Rows 1 through 0 of 0'. A 'Customer Survey/Complaint Form' button is located at the bottom center of the page.

Step 2

The following screen will appear:

Complete the following fields:

Facility

Program (choose CPT-CMS/STD Prophy Meds)

Product (contains only medications CPT staff are approved to order)

Quantity

Florida Department of Health - Pharmaceutical Forms System - Microsoft Internet Explorer

Address: http://www.fdohcentralpharmacy.com/RepackPharmaceuticalRequestForm.aspx

LEXMARK Print Now: Normal Black and White Text Only Picnik Preview Schedule

Pharmaceutical Forms System

floridashealth.com

Prepack Pharmaceutical Request Form

Request Details

Date Requested:
8/13/2010 12:33:58 PM

***Status:**
In Progress

***Requestor Name:**
Teresa Morris

***Contact Telephone:**
format: 999-999-9999
(850) 111 - 111 ext:

***DEA Permit Number:**
xxx

*Bureau of Statewide Pharmaceutical Services
104-2 Hamilton Park Drive
Tallahassee, FL 32304
850-922-9036
Permit # 28:29, 54:33, 50:23B*

Request Number:
BSPS2010-08-13T12_33_58

***Facility:**
Select a Facility

Ship To Address:

Attn:

Street Address:

City:

State:

Zip Code:

County:

***Ordering Facility's Pharmacy Permit Number:**

Requestor E-Mail Address:
teresa_morris@doh.state.fl.us

Program And Product Table

To add a row, fill out the information below and click the **Add Row** button. If a row needs to be deleted click the **Delete** Button next to the row. When you are finished filling out the form click the **Submit** button and close the form by clicking **Return Home**.

*Program: Select a Program	*Product: Select a Product	*Quantity: 	Add Row
-------------------------------	-------------------------------	----------------	---------

Step 3
The completed screen

Florida Department of Health - Pharmaceutical Forms System - Microsoft Internet Explorer

Address: http://www.fdohcentralpharmacy.com/RepackPharmaceuticalRequestForm.aspx

LEXMARK Print Now: Normal Black and White Text Only Picnik Preview Schedule

Prepack Pharmaceutical Request Form

Request Details

Date Requested:
8/13/2010 12:34:44 PM

***Status:**
In Progress

***Requestor Name:**
Teresa Morris

***Contact Telephone:**
format: 999-999-9999
(850) 111 - 111 ext:

***DEA Permit Number:**
xxx

*Bureau of Statewide Pharmaceutical Services
104-2 Hamilton Park Drive
Tallahassee, FL 32304
850-922-9036
Permit # 28:29, 54:33, 50:23B*

Request Number:
BSPS2010-08-13T12_34_44

***Facility:**
A TEST FACILITY A TEST FACILITY - BROWARD Anywhere

Ship To Address:

Attn:

Street Address: Anywhere

City: Somewhere

State: FL

Zip Code: XXXXX

County: BROWARD

***Ordering Facility's Pharmacy Permit Number:**

Requestor E-Mail Address:
teresa_morris@doh.state.fl.us

Program And Product Table

To add a row, fill out the information below and click the **Add Row** button. If a row needs to be deleted click the **Delete** Button next to the row. When you are finished filling out the form click the **Submit** button and close the form by clicking **Return Home**.

*Program: CPT-CMS/STD Prophyl. Meds	*Product: Select a Product	*Quantity: 	Add Row
--	-------------------------------	----------------	---------

Step 4

After all the required fields are complete hit submit button located at the bottom of the screen.

Florida Department of Health - Pharmaceutical Forms System - Microsoft Internet Explorer

File Edit View Favorites Tools Help

Back Forward Stop Home Search Favorites Print Now: Normal Black and White Text Only Picnik Preview Schedule

Address http://www.fdohcentralpharmacy.com//RepackPharmaceuticalRequestForm.aspx Go Links

Request Details

Date Requested: 8/13/2010 12:36:25 PM

Request Number: BSPS2010-08-13T12_36_25

*Status: In Progress

*Facility: A TEST FACILITY A TEST FACILITY - BROWARD Anywher

*Requestor Name: Teresa Morris

Ship To Address:

Attn:

Street Address: Anywhere

City: Somewhere

State: FL

Zip Code: XXXXX

County: BROWARD

*Contact Telephone: format: 999-999-9999

(850) 111 - 111 ext:

*DEA Permit Number: xxx

*Bureau of Statewide Pharmaceutical Services
104-2 Hamilton Park Drive
Tallahassee, FL 32304
850-922-9036
Permit # 28:29, 54:33, 50:238*

*Ordering Facility's Pharmacy Permit Number:

Requestor E-Mail Address: teresa_morris@doh.state.fl.us

Program And Product Table

To add a row, fill out the information below and click the **Add Row** button. If a row needs to be deleted click the **Delete** Button next to the row. When you are finished filling out the form click the **Submit** button and close the form by clicking **Return Home**.

*Program: CPT-CMS/STD Prophyl. Meds	*Product: Select a Product	*Quantity:	Add Row
-------------------------------------	----------------------------	------------	---------

Submit Cancel

Version Information

Done Internet

CPT STD Prophylactic Inventory Log:

The following information must be collected on the Inventory Log:

- Medication Description
- Pkg Size
- Beginning Inventory
- Additional Received this period
- Dispensed Medication
- Quantity in Stock
- Ending Inventory
- Difference
- National Drug Code
- Expiration Date

National Drug Code and the Expiration Date are located on the medication label. Log sheet must be maintained by CPT for (6) years

Handling of expired STD medications:

CPT staff are responsible for developing a policy for routinely checking expiration dates on the CPT STD medications. Expired STD medications must be returned to DOH central pharmacy at the following address: 116A Hamilton Park Dr. Tallahassee, Florida 32304. The ***Prescription Return Form***, which is included in Appendix F., must be completed for all expired STD medications returned to the DOH central pharmacy. The completed form is to be sent electronically to the DOH pharmacy and a copy of the form will accompany the returned medications.

Specimen collection and handling:

Specimens should be collected as soon as possible after onset and transported immediately to the laboratory. Each CPT provider site can use the laboratory of their choice to process specimens. Bureau of STD will only cover the laboratory costs if the DOH Laboratory is used.

STD specimens collected by the CPT staff can be submitted to the FDOH laboratory, www.doh.state.fl.us/lab/index.htm along with the laboratory request form **DH1847**, which is included in Appendix F.


Request form DH1847, urine collection kits, and swab collection kits for gonorrhea and Chlamydia testing can be ordered by faxing a request to Bureau of Laboratories' supply department at (904)791-1637. The phone number for the state laboratory is: **(904) 791-1571**. Collection materials for herpes testing are not available through the state laboratory. Herpes Simplex Virus (HSV) testing is only available in the Jacksonville and Tampa laboratories. Chlamydia trachomatis (CT) and Gonorrhea testing is available at all five Bureau of Laboratory locations.

CPT STD Instructions for specimen collection and shipping of specimens is included in the following attachments located in Appendix F:

- APTIMA® Unisex Swab Specimen Collection Kit for Endocervical and Male Urethral Swab Specimens
- APTIMA® Urine Specimen Collection Kit for Male and Female Urine Specimens
- COLLECTION AND SHIPPING OF SPECIMENS FOR HERPES SIMPLEX VIRUS (HSV) EXAMINATION

CPTIS STD DATA ELEMENTS:

Federal and State requirements include the collection of data elements which will be reported to the DOH STD office. These data elements will be collected in CPTIS. The data will be collected in CPTIS on the Assessment screen. The data elements will be collected on children served by the CPT who receive STD prophylactic medications. When a sexual abuse exam is performed and the child has finding, the attached screen will appear at the bottom of the assessment screen.

STD Assessment	
<p>Sexual Activity within 60 days:</p> <p><input checked="" type="radio"/> Yes</p> <p><input type="radio"/> No</p> <p><input type="radio"/> Undetermined</p>	<p>Signs and Symptoms:</p> <p><input type="checkbox"/> Abdominal pain</p> <p><input type="checkbox"/> Discharge</p> <p><input type="checkbox"/> Edema of genitals</p> <p><input type="checkbox"/> Erythema of genitals</p> <p><input type="checkbox"/> Genital itching</p> <p><input type="checkbox"/> Genital odor</p> <p><input type="checkbox"/> Genital or anal bleeding</p> <p><input type="checkbox"/> Genital pain</p> <p><input type="checkbox"/> Genital ulcers or lesions</p> <p><input type="checkbox"/> NONE</p> <p><input type="checkbox"/> Urinary symptoms</p>
<p>Presumptive Diagnosis:</p> <p><input type="checkbox"/> Chlamydia</p> <p><input type="checkbox"/> Gonorrhea</p> <p><input type="checkbox"/> Herpes</p> <p><input type="checkbox"/> Other</p> <p><input type="checkbox"/> Syphilis</p>	<p>Pregnancy Test:</p> <p><input type="radio"/> Administered -- Positive Result</p> <p><input checked="" type="radio"/> Administered -- Negative Result</p> <p><input type="radio"/> Not Administered</p>
<p>Treatments:</p> <p><input type="checkbox"/> Azithromycin PO 1 gram</p> <p><input type="checkbox"/> Cefixime (Suprax) PO 400 mg</p> <p><input type="checkbox"/> Metronidazole (Flagyl) PO 2 grams</p> <p><input type="checkbox"/> NONE</p>	<p>Referred for Follow-Up:</p> <p><input type="checkbox"/> HIV Testing and Treatment (EP)</p> <p><input type="checkbox"/> HPV</p> <p><input type="checkbox"/> Other</p> <p><input type="checkbox"/> Syphilis</p>
<p>Specimens Collected:</p> <p><input type="checkbox"/> Chlamydia</p> <p><input type="checkbox"/> Gonorrhea</p> <p><input type="checkbox"/> Herpes</p> <p><input type="checkbox"/> HIV</p> <p><input type="checkbox"/> Other</p> <p><input type="checkbox"/> Syphilis</p>	
<p>Referred To: -- </p>	<p>Date/Time of Medical Services: 03/03/2010 18:55</p>
<p><input type="text"/> Comments: (max 255 characters)</p>	

The CPTIS User's Guide provides instructions for completing the data fields.

Child Protection Team

Telemedicine Network:

A Guidebook



The Division of Prevention and Intervention, Children's Medical Services (CMS) , Florida Department of Health, provides programmatic oversight, technical assistance, network support and training to the Child Protection Team (CPT) Telemedicine Network.

This Guidebook provides information about the use of telemedicine technologies in the assessment of children alleged to be abused, neglected, or abandoned.

The CPT Telemedicine Network is relatively new and innovative and issues periodically surface which may require revision of this guide. CMS will distribute such revisions to participating Child Protection Team telemedicine programs and will post them on the Department of Health Intranet, as needed.

The Department of Health, Children's Medical Services, provides funding for the Child Protection Team Telemedicine Network and the publication of this Guidebook.

TABLE OF CONTENTS

CHAPTER 1: CHILD PROTECTION TEAMS GENERAL INFORMATION

- 1.1 Background**
- 1.2 Purpose and Role**
- 1.3 Team Composition**
- 1.4 Team Assessment Process**
- Figure 1: Child Protection Team Regions**
- Figure 2: Child Protection Team Offices**

CHAPTER 2: CPT TELEMEDICINE NETWORK

- 2.1 Background**
 - Figure 3: CPT Telemedicine Network**
- 2.2 Purpose and Goal**
 - Figure 4: CPT Offices and Telemedicine Sites**
- 2.3 Components of the CPT Telemedicine Network**
 - Figure 5: Typical Telemedicine Equipment**
- 2.4 Need for Community Involvement**
- 2.5 Required Steps for the Implementation of CPT Telemedicine (Hub and Remote Sites)**

CHAPTER 3: ROLES AND RESPONSIBILITIES OF STAFF PROVIDING CPT TELEMEDICINE SERVICES

- 3.1 Health Professional Requirement to Report Suspected Abuse and Neglect**
- 3.2 Roles of Local Staff in the CPT Telemedicine Network**
 - 3.2.1 General Information**
 - 3.2.2 CPT Medical Director/CPT Team Coordinators**
 - 3.2.3 CPT Physician/Physician Extender**
 - 3.2.4 Registered Nurse**
- 3.3 Instructions for the Health Care Provider Regarding the CPT Telemedicine Exam**

CHAPTER 4: TECHNICAL (TELEMEDICINE EQUIPMENT)

- Illustration 1: A Typical Telemedicine System**
- Illustration 2: A Typical General Examination Camera**
- Illustration 3: The Tandberg Intern Telemedicine System**
- Illustration 4: Cables, Connectors, and Adapters**
- Illustration 5: The Tandberg Remote Control**
- Flow Chart 1: Trouble-Shooting Flow Chart for ISDN Sites**

ATTACHMENT 1: DEFINITIONS

ATTACHMENT II: REQUEST FOR APPROVAL TO IMPLEMENT CPT TELEMEDICINE PROGRAM

ATTACHMENT III: REQUEST FOR APPROVAL TO CHANGE TELEMEDICINE SITE OR MOVE TELEMEDICINE EQUIPMENT

ATTACHMENT IV: CPT TELEMEDICINE FACTSHEET

ATTACHMENT V: DOH STRATEGIC PLAN TELEHEALTH WORKGROUP

CHAPTER 1: CHILD PROTECTION TEAMS GENERAL INFORMATION

1.1 Background

The State of Florida mandated the reporting of suspected child abuse and neglect in 1971, resulting in a dramatic increase in abuse reports investigated by the State. Section 827.07, Florida Statutes, required that child abuse investigators “include a determination of harm or threatened harm to each child, the nature and extent of present or prior injuries, abuse, or neglect, and evidence thereof.”

The need for a specialized medical resource was recognized and a plan was developed to provide a medically directed multidisciplinary team pilot project administered by the Children’s Medical Services (CMS) Program. This plan culminated in a legislative appropriation in 1978.

The success of the first Child Protection Team (**CPT**) established in Jacksonville in 1978 led to the gradual expansion of this system. The 1999 Florida Legislature passed comprehensive child protection reform that greatly expanded the role of the CPTs. Criteria were developed for mandatory referral by the Department of Children and Families (DCF), or other agencies responsible for child protective investigations, to the CPTs. CPTs are now responsible for reviewing all reported cases of child abuse and neglect to the DCF hotline to determine which reports meet mandatory referral criteria and are in need of CPT services.

Please refer to Figures 1 and 2 for additional information about CPT Regions and office locations.

1.2 Purpose and Role

Child Protection Teams are medically directed interdisciplinary teams developed to supplement the Department of Children and Families child protection programs by providing medical and social assessments for reports of suspected child abuse and neglect. Teams are available 24 hours a day, seven days a week. Team assessments provide documentation of indicators of abuse or neglect, if present. In situations where abuse or neglect is indicated, teams provide supportive documentation to help assure the safety of the child through both legal and social interventions. The teams also make recommendations for interventions to reduce the risk of re-abuse and enhance families’ capabilities to provide a safe, abuse-free home, whenever possible.

The Child Protection Teams are community-based, functioning as an independent consultative and review resource. The Division of Prevention and Intervention contracts annually with the community providers for CPT services. Teams use state appropriations to provide core services and work with local resources to develop additional services based on community needs. They are examples of public/private partnerships in action. Teams have developed formal and informal protocols in many communities to clarify roles of agencies dealing with abused and neglected children.

In many instances, DCF staff works with other local agencies involved in responding to an abuse report (e.g., law enforcement). In these cases, the CPT may function as the focal point for the community assessment process. In this role, teams may conduct videotaped interviews with a physically or sexually abused child or provide other documentation of injuries for use by several agencies.

1.3 Team Composition

Each CPT functions under the administrative direction of a medical director. This individual is a CMS consultant who is a board-certified pediatrician with specific expertise and training in child abuse and neglect. Additional CMS consultant pediatricians work for the team either on a fee for service or contract basis. Consultation is provided to other physicians from the private community to assist them in the evaluation of any child. Some teams have advanced registered nurse practitioners (ARNPs) and additional medical staff who

work with a CMS CPT pediatrician.

Coordination of assessment activities is the responsibility of the team coordinator who must have a bachelor's or master's degree in psychology, social work, nursing, or another behavioral science, three years of experience in the field of child abuse and neglect, and experience in program management. Case coordinators, varying in number depending on the size of the team, provide the individual casework and assessment activities. Case coordinators are generally social workers or nurses. All teams have a licensed psychologist either on staff or on contract. Teams also include lawyers, when needed.

Team staffing on individual children include the DCF worker responsible for the assessment and disposition of the particular child's case. As the assessment process is generally multi-agency and community-based, the diagnostic and assessment process may also include law enforcement, an attorney working with the CPT, the state attorney, school personnel, and community agencies working with the child and family.

1.4 Team Assessment Process

Team referrals made as close to the time of the report as possible, offer the best opportunity for the teams to provide useful evaluative direction to the investigative process. In responding to the referral for medical evaluations and other assessment services, the team works within the time frame mandated by statute for conducting child protective investigations. Positive medical findings are verbally shared immediately with DCF and law enforcement. A rapid response may also be appropriate if medical findings are needed for an initial safety assessment to assist the child protective investigator in determining the child's immediate risk of further abuse.

Upon referral of a child, the teams determine what assessment activities are needed and appropriate. Each assessment is tailored to the specific child and family and the maltreatment allegation. These diagnostic services may be either limited or extensive in scope.

An interdisciplinary team approach is used to assess each child. The assessment addresses the validity of abuse allegations, the identification of risk factors of abuse/neglect, and the plans for reducing the risk of further abuse by recommending interventions for the child and family.

The team assessment is based upon the evaluation of existing information from multiple sources and a variety of direct assessment activities tailored to the specific child, the family, and the particular situation. CPT assessments offer a unique medically based foundation for the interdisciplinary process of assessing risk. The assessment may include medical diagnosis and evaluation, medical consultation, specialized interviewing of children, family psychosocial assessment, psychological evaluation, other specialized assessments, and interdisciplinary staffing. The teams are also statutorily mandated to provide expert testimony in court cases.

Figure 1: Child Protection Team Regions

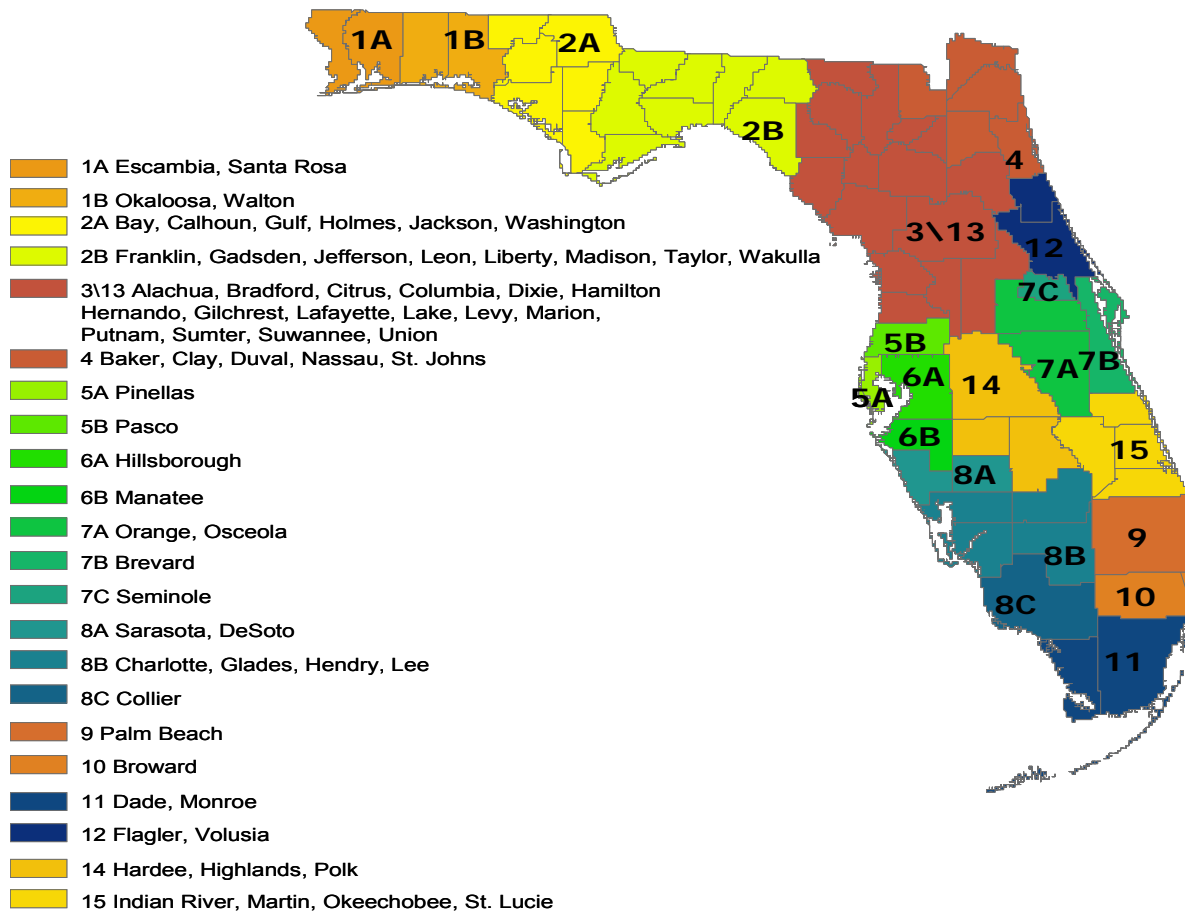
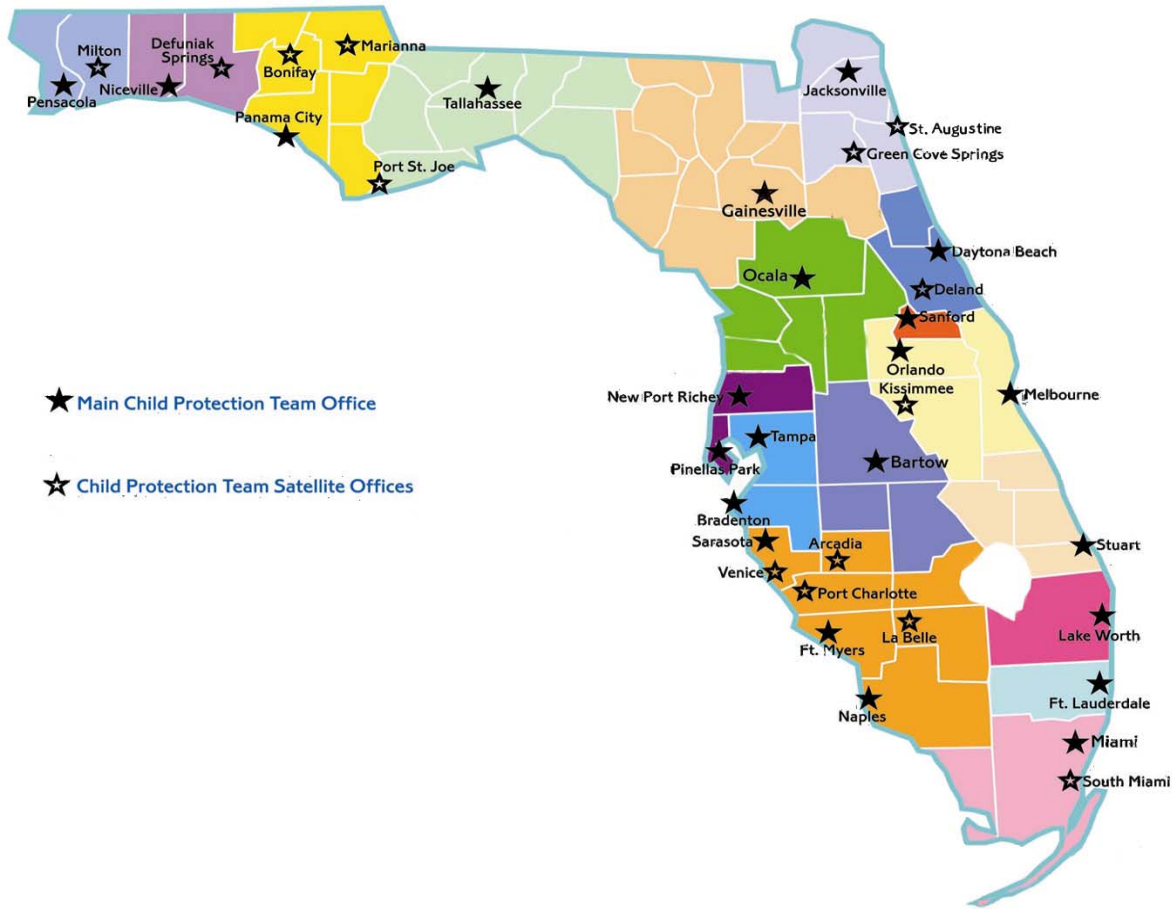


Figure 2: Child Protection Team Offices



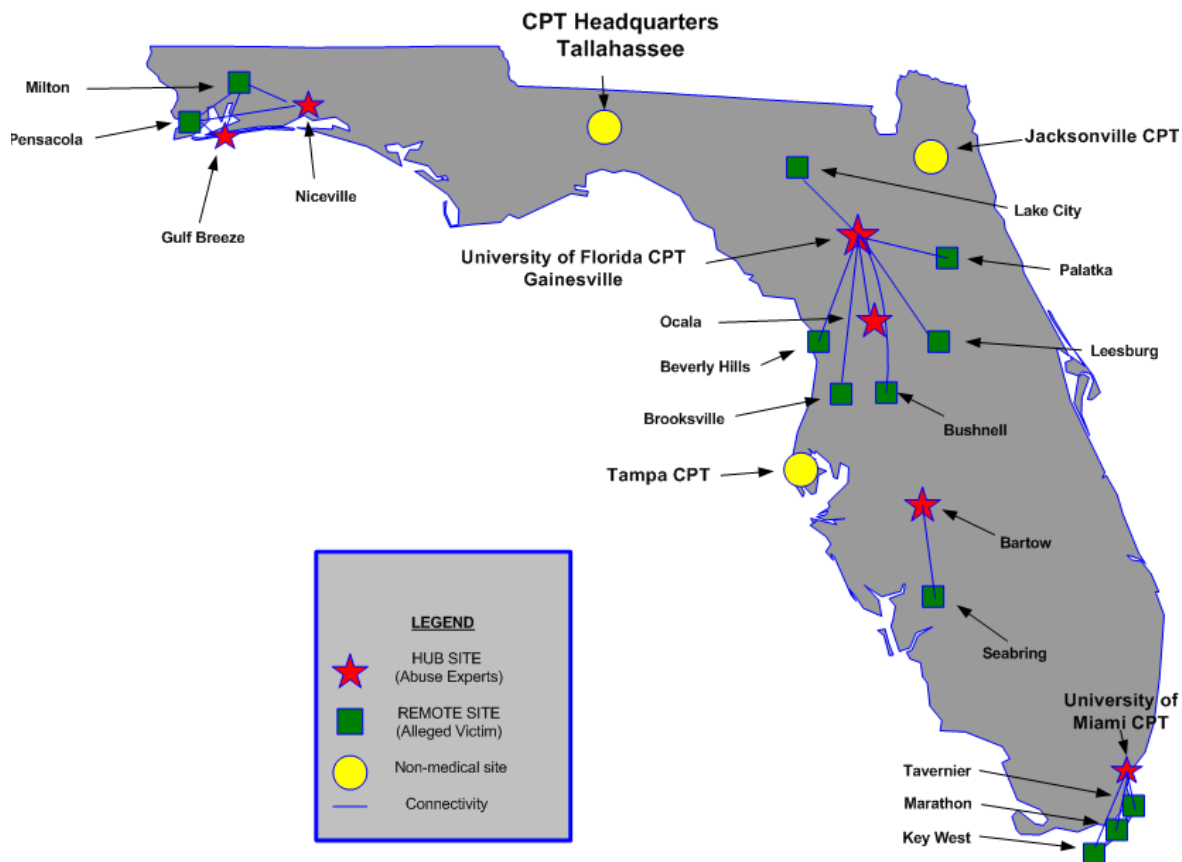
CHAPTER 2: CPT TELEMEDICINE NETWORK

2.1 Background

In 1998, Children's Medical Services (CMS) developed a pilot real-time telemedicine network for the evaluation of children suspected to be abused or neglected as an alternative to establishing additional child protection teams. Telemedicine refers to the use of electronic communication and information technologies to provide or support clinical care at a distance. [Joint Working Group's "*Telemedicine Report to Congress*," 01-01-97] In other words, the doctor or nurse practitioner is some distance from the patient with some means of communications existing between the two sites so the examiner can see, hear, and assess the patient. This was the first time in the nation that real-time telemedicine had been used in this field.

Please see Figure 3 for a graphical depiction of the CPT Telemedicine Network.

**Figure 3: CPT Telemedicine Network
November 2008**

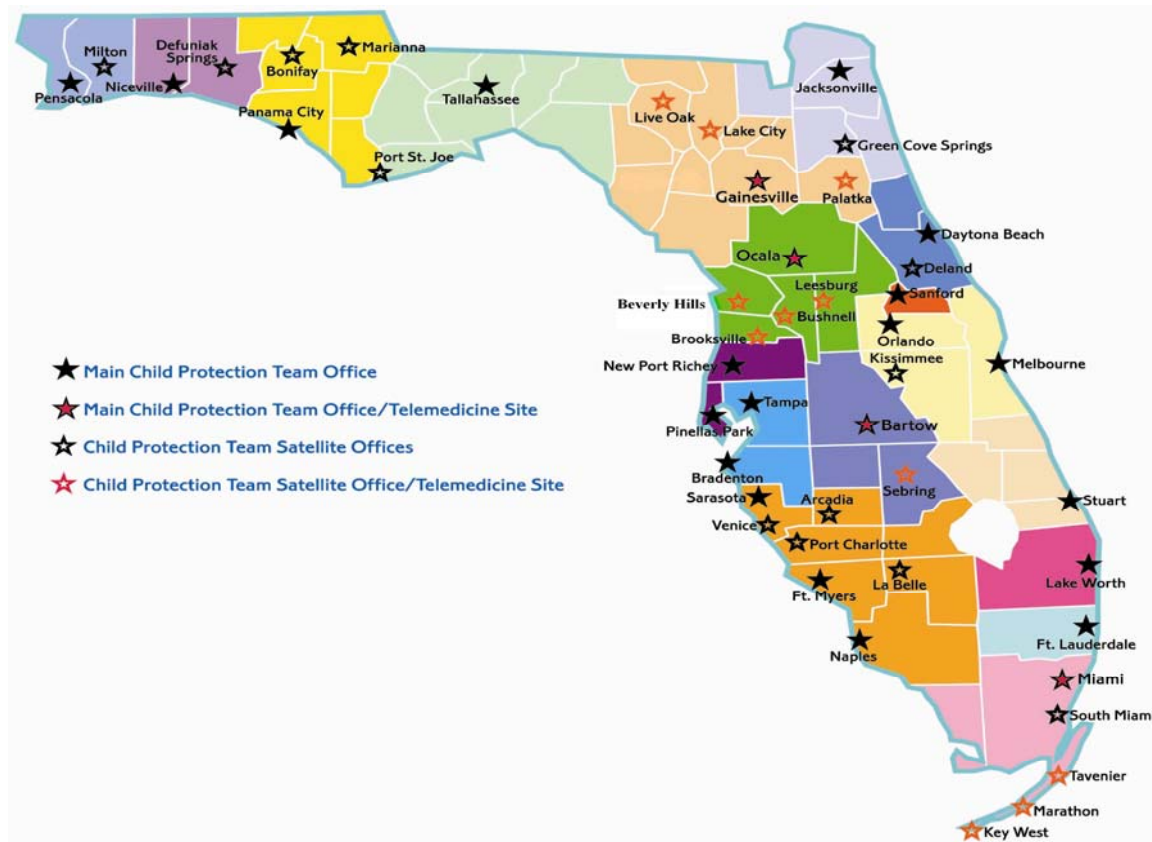


2.2 Purpose and Goal

The purpose and goal of the CPT Telemedicine Network is to improve access to CPT specialty healthcare services (such as medical exams) for children suspected of abuse and neglect. Medical providers with expertise in the area of child abuse and neglect provide the medical exams. Use of this platform allows for timely 'local' exams, such that the child does not have to endure additional travel that may have been typically required in the past in order to access these services.

Please see Figure 4 for additional information regarding CPT office and Telemedicine site locations.

Figure 4: CPT Offices and Telemedicine Sites



2.3 Components of the CPT Telemedicine Network:

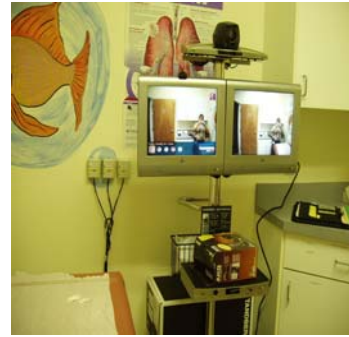
The CPT Telemedicine Network provides for the performance of child assessments via electronic communication and information technologies between Main (hub) and Satellite (remote) sites. Hub sites are facilities with a wide range of available medical and interdisciplinary professional staff. Remote sites are typically smaller facilities in less urbanized areas with limited diversity in medical and non-medical expertise. Each hub site is responsible for electronically providing expert levels of medical child abuse assessments to specific remote sites.

Figure 5 provides two examples of telemedicine equipment typically used in this network. Telemedicine equipment will allow medical staff to transmit live (real-time) child abuse assessments between hub and remote sites. The equipment enables a health care practitioner at a remote site to perform an assessment that is electronically transmitted to a hub site where child abuse experts can observe the assessment and consult with the remote site practitioner. The equipment has camera features providing clinical quality images that allow professional staff viewing the assessments at a different location to see external and internal physical examinations. Using this approach, the child abuse expert becomes the examiner of record.

Figure 5: Typical Telemedicine Equipment



Typical Telemedicine Hub System



Typical Telemedicine Remote System

In addition to the Typical Telemedicine Hub & Remote System equipment shown above, the following equipment may also be used:

- Personal Computer
- Child Abuse Image and Data Management Software (e.g.; Second Opinion Professional)
- Peripheral Camera Equipment (e.g.; AMD-2500 General Examination Camera)
- Colposcope (examples include those manufactured by Leisegang or Welch-Allyn)

2.4 Need for Community Involvement

One of the “lessons learned” from the pilot telemedicine project was the importance of early understanding and buy-in of local agencies and staff who are involved in child protection and child health. Respecting this dynamic, it is crucial to conduct a minimum of one community meeting to discuss the concept of telehealth and telemedicine with all interested parties in the proposed hub and remote site. This meeting should be held early in the planning process.

The following agencies/facilities should be involved in this meeting:

- Hub CPT staff, including medical director and team coordinator, at a minimum
- Children’s Medical Services Central Office staff
- Local DCF staff
- Local law enforcement staff, including sheriff, police and FDLE (if appropriate)
- State’s Attorney’s office staff
- County health department staff
- Local hospital staff, including nursing and administration
- Staff from other facilities or agencies involved with child protection (e.g., Children’s Advocacy Center)

The purpose of this meeting is to explain the use of advanced telecommunications technologies in the child abuse and neglect arena and the benefits these technologies may provide to children, child protection investigation staff, local law enforcement, and medical professionals. Discussion and agreement about use, equipment placement and various responsibilities should be reached. Below is a suggested outline/format for the community meeting.

1. Introductions and purpose of meeting
2. Overview/background of the Child Protection Team Telemedicine Network
3. Need for telemedicine in this community
4. Benefits of these technologies

5. Demonstration
6. Review of draft agreement
7. Discussion of pertinent issues and obligations
8. Hands-on demonstration, if requested

2.5 Required Steps for the Implementation of CPT Telemedicine (Hub and Remote Sites):

- A. Local CPT staff must complete and submit a “Request for Approval to Implement CPT Telemedicine Program” form to CMS, Division of Prevention and Intervention, for review and approval prior to the implementation of the program. (Attachment II)
- B. Development of the operational plan by central office staff which includes:
 - Telemedicine Budget
 - Identification of the remote and hub sites
 - Internal operating procedures (IOP) for each site both remote and hub. IOP may vary for each site.
 - Identification of a local telemedicine program coordinator (to serve as a contact for administrative and/or programmatic issues).
 - Identification of a local telemedicine equipment coordinator (trained to provide 'simple' technical support in conjunction with CPT Central Office staff and others, such as with connecting equipment cables and turning on equipment); this person will participate in periodic maintenance videoconference calls and be available for troubleshooting.
 - Identification of a technical support service provider (this is a person or a service provider that will handle 'in-depth' technical troubleshooting and equipment replacement).
 - Identification of a plan for backing up information collected during the telemedicine exam
 - Training plan for the CPT medical director, the telemedicine coordinator, and telemedicine equipment coordinator in the operation of the telemedicine network and equipment.
 - Training plan for the medical director or his/her designee to provide training to the nursing staff in the remote sites regarding the recognition of child physical and sexual abuse.
- C. Negotiate and execute a written agreement between the hub site and each remote site
- D. Development of a plan for the following:
 - Provision of ongoing technical support to the staff providing the telemedicine exams in both the remote and hub sites
 - Coordination and participation of the medical director and telemedicine program coordinator in community meetings.
 - The assignment a case coordinator to the county where the telemedicine unit is located.
 - The utilization of the telemedicine technologies for training, continuing education and other purposes, as appropriate.
 - Ongoing connectivity and maintain a minimum level of technical skill and comfort in the staff of the remote sites.
 - Data collection.
 - Secure storage of the telemedicine equipment.

CHAPTER 3: ROLES AND RESPONSIBILITIES OF STAFF PROVIDING CPT TELEMEDICINE SERVICES

3.1 Health Professional Requirement to Report Suspected Child Abuse and Neglect

Section 39 of the Florida Statutes mandates that any person who knows, or has reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver, or other person responsible for the child's welfare shall report immediately such knowledge or suspicion to the central abuse hotline of the Department of Children and Families.

THE FLORIDA ABUSE HOTLINE WILL ACCEPT A REPORT WHEN:

- There is reasonable cause to suspect that a child (an unmarried person under the age of 18 who has not been emancipated by order of the court),
- The child can be located in Florida, or is temporarily out of the state but expected to return,
- The child has been harmed or is believed to be threatened with harm,
- And the alleged abuser is a parent, legal custodian, caregiver, or other person responsible for the child's welfare.

The name of any person reporting child abuse, abandonment, or neglect may not be released to any person other than employees of the department responsible for child protective services, the central abuse hotline, law enforcement, or the appropriate state attorney, without the written consent of the person reporting. This does not prohibit the subpoenaing of a person reporting child abuse, abandonment, or neglect when deemed necessary by the court, the state attorney, or the department, provided the fact that such person made the report is not disclosed.

The CPT Telemedicine Network program does not alter the statutory requirement for health care practitioners to report suspected abuse to appropriate authorities. Suspected abuse by a caretaker is reported to the Hotline (1-800-96-ABUSE [962-8273]). In addition, all sexual abuse is a crime and is reported to local police authorities. Telemedicine can help local health care providers determine if there is a reason to suspect and can expedite child placement decisions by providing expert opinions regarding abuse or neglect.

3.2 Roles of Local Staff in the CPT Telemedicine Network

3.2.1 General Information:

Only CPT physicians/physician extenders (Advance Registered Nurse Practitioners or Physician Assistants) approved as CMS medical providers and specifically trained to do telemedicine exams can perform these exams at the hub site. Only registered nurses (RNs) specifically trained to assist with telemedicine exams can participate in the CPT medical exam at the remote site. All persons at the remote site will act under the direct supervision of the telemedicine physician or physician extender (ARNP).

3.2.2 CPT Medical Director/CPT Team Coordinators:

Responsibilities include:

- Assure all CPT medical provider/extendors involved in the CPT Telemedicine program are CMS approved medical providers.
- Assure all CPT staff involved in the CPT Telemedicine receives adequate training in the provision of CPT medical exams provided via telemedicine.
- Assure that CPT Telemedicine Internal Operating Procedures (IOP) are developed and that staff are trained on the procedures.
- Assure that a copy of the CPT Telemedicine IOP, CPT Handbook, and the Telemedicine Guidebook are located at each remote and hub site and that staff is made aware of their location.

- Collect and provide telemedicine-related data to CPT Central Office, as required. An example of the data collection requirements include tracking the number of telemedicine-based exams performed from each hub site in association with the State Surgeon General's Quarterly Performance Review (this Review compares the number of telemedicine-based examinations provided to the total number of medical evaluations performed in counties where telemedicine capability exists).
- Adhere to all DOH, State of Florida, Federal, and other policies related to security and confidentiality.
- Notify program office staff (contract manager) with changes in CPT telemedicine staff or CPT telemedicine budget
- Complete and submit a "Request for Approval to Change Telemedicine Site or Move Telemedicine Equipment" form to CMS, Division of Prevention and Intervention, for review and approval prior to change being implemented. (Attachment III)

3.2.3 CPT Physician/Extender

Responsibilities include:

- To be approved as a CMS medical provider.
- Supervises RN who is assisting with the telemedicine CPT medical exam at the remote site.
- Assume clinical responsibility for the examination.
- Be familiar with the CPT Telemedicine IOP, CPT Handbook, and the Telemedicine Guidebook.
- Attend telemedicine training.
- Adhere to the DOH security and confidentiality policy.

3.2.4 Registered Nurse

Responsibilities include:

- Be familiar with the CPT Telemedicine IOP, CPT Handbook, and the Telemedicine Guidebook.
- Attend telemedicine training.
- Adhere to the DOH security and confidentiality policy.

3.3 Instructions for the Health Care Provider Regarding the CPT Telemedicine Exam

- Prior to the initiation of the exam the telemedicine nurse should explain how the exam is going to be conducted (give the CPT Telemedicine Fact Sheet – Attachment IV) and allow the child and family an opportunity to ask questions. The nurse should take whatever time is necessary to develop rapport and a trusting relationship with the child including a hands-on experience with the equipment. The nurse is the source of support for the child before, during, and after the examination when recommendations must be carried out. The telemedicine nurse will be the "hands" of the telemedicine examiner for every part of the examination.
- Telemedicine may be a foreign concept to children and parents alike. Parents should be reminded that these technologies could greatly obviate the need for a long trip and give them access to an examiner more easily than by other means. The procedure should be introduced as a type of medical consultation with an expert in children's problems. Telemedicine may often be viewed as "being on television" and, therefore, be suspect in terms of privacy issues. The patient should be assured that the process is like a video telephone and that only they and the person seen on the screen can view the exam. The telemedicine examiner will have a conversation with the child to also help alleviate fears.
- Examinations of allegedly abused or neglected children require attention to special considerations. For example, the child should never be asked about abuse in the presence of a possible perpetrator. Older children and adolescents are usually reticent about talking about sexual matter with their parent in the room. Therefore, parents must be excluded from history taking and examination in some cases. As a

rule, ask the child who they might prefer to be with them during the examination and allow them to choose one person.

- Parental permission for procedures is essential unless law enforcement has found probable cause or the Department of Children and Families has declared jurisdiction over a case. In the latter cases, tests of any kind can be done under the jurisdiction of the State without parental permission. Sharing of information with a parent is a matter of judgment. In general, the older the child, the stronger is your responsibility not to share information without the permission of the child.
- Once a report of abuse has been made, the records of the medical evaluation become the property of the child protection team and as such are subject to different confidentiality statutes than apply to medical records in general. You cannot share a copy of the written record with the parent. Other investigators should seek records from the child protection team. Procedures for evidence handling will be developed to insure chain of custody of all records of the examination. Do not discuss forensic cases with attorneys or anyone else. Refer all requests to the examiner of record.
- Confidentiality of the telemedicine encounter is assured by transmission over secure telecommunications lines. The telemedicine nurse will be subject to the same confidentiality rules as the telemedicine examiner.

CHAPTER 4: TECHNICAL (TELEMEDICINE EQUIPMENT)

With each telemedicine unit, the following equipment may be included:

- Cameras – a main camera and at least one other camera (called a peripheral camera).
- Codec – a compressor/decompressor (or coder/decoder) unit; this is considered to be “brain” of the system.
- Monitor(s) - used for viewing local and/or remote site video images.
- Cables and network equipment/connections.
- Computer (primarily at hub sites).
- Colposcope - a magnifying instrument designed to facilitate visual inspection of the vagina and cervix. The colposcope may utilize a camera to capture images that will serve as part of the permanent record of the examination.

The camera produces a video signal that is digitized and compressed by the codec and transmitted via the network to the other site where that system 'reconstructs' and presents the information so that the medical practitioner can see the same video picture you are sending.

In addition, the examiner will be capturing still images of the patient, as needed, to supplement the medical record.

When considering the implementation of a new telemedicine program, you may wish to utilize the following estimated figures for budget purposes:

Network Services:

ISDN: \$600/site NRC (non-recurring cost; for network services installation) + \$150 to \$250/site/month (this is a monthly recurring cost) + \$50 to \$100/hr (for long distance services)

NOTE: it may be possible to use MyFloridaNetwork (MFN) services (may range from \$300 to \$600/site/month); Note that the use of MFN services must receive prior approval from the CPT program office.

Equipment: \$40,000/site NRC (non-recurring cost for equipment) + \$3,000/year (annual equipment extended warranty services; this cost only applies after the first year)

NOTE: it may be possible to reduce these costs somewhat, depending on the application and our ability to negotiate pricing with the equipment supplier.

Support Services: on-site technical support services costs are difficult to predict; a recent budget request identified this cost as being \$15,540/site/year; however, it may be possible to arrange a support contract with a local vendor for 'on demand' services that will cost less than this amount. It should be noted that the need for adequate technical support services are considered crucial to the successful implementation of a CPT Telemedicine Program!

CPT Central Office technical staff is available to discuss and provide recommendations in support of your telemedicine program needs.

The following illustrations and troubleshooting flow chart are provided to provide further insight into the equipment normally used and typical processes that may be involved in resolving equipment or network issues in the CPT Telemedicine Network.

Illustration 1: A TYPICAL TELEMEDICINE SYSTEM

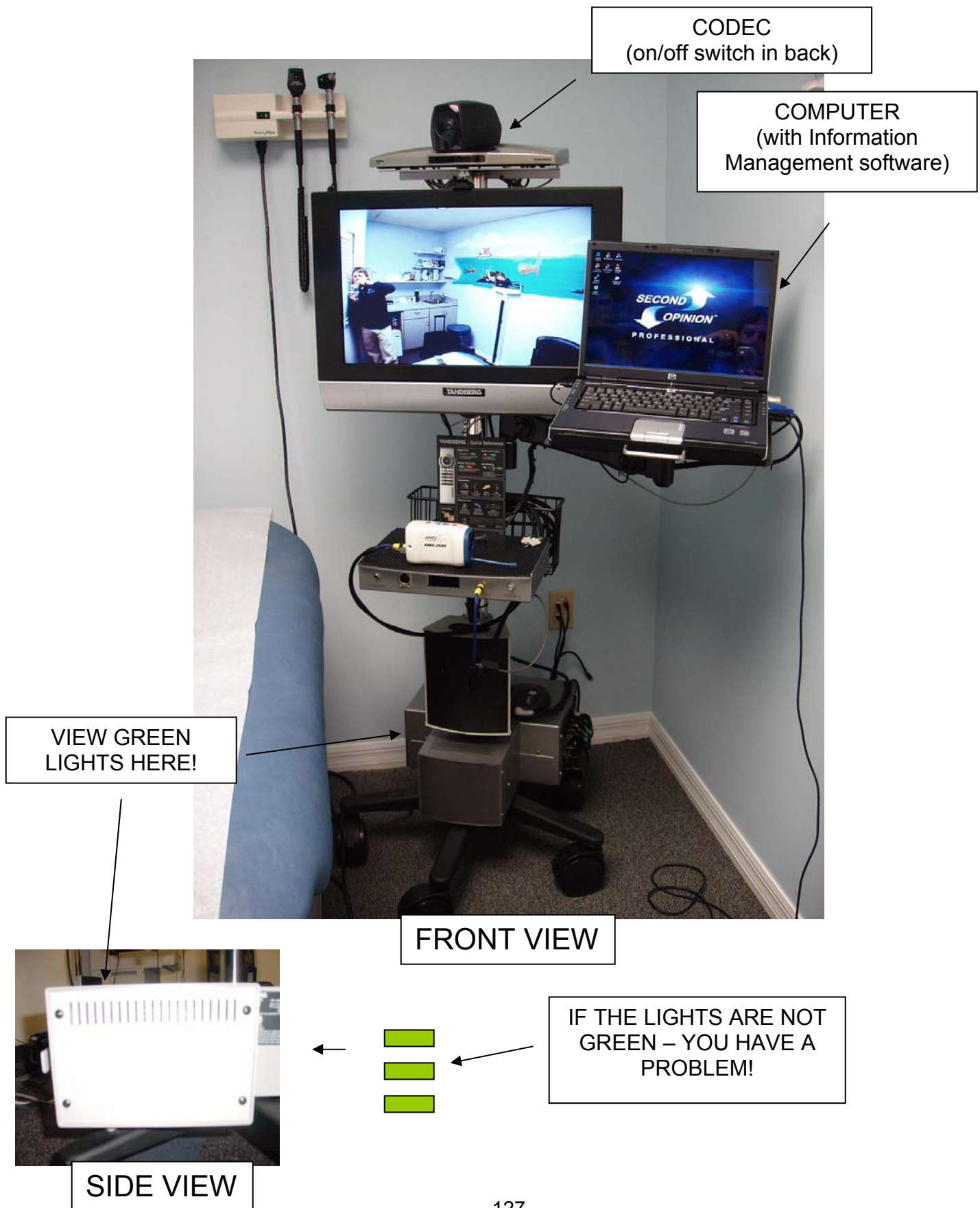


Illustration 2: A TYPICAL GENERAL EXAMINATION CAMERA



- On/off switch (back of camera)
- Light switch (back of camera)
- Zoom in/out (top of camera)
- Auto focus (back of camera)
- Freeze frame (top of camera)

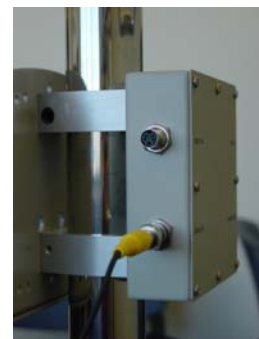
(1) Patient Camera backside, (2) patient camera cabling, and (3) patient camera input to RCA port using a BNC-to-RCA adapter (SEE ILLUSTRATION 4 FOR A picture of the ADAPTER)



1



2



3

Illustration 3: THE TANDBERG INTERN TELEMEDICINE SYSTEM

At a Glance — The TANDBERG Intern II System

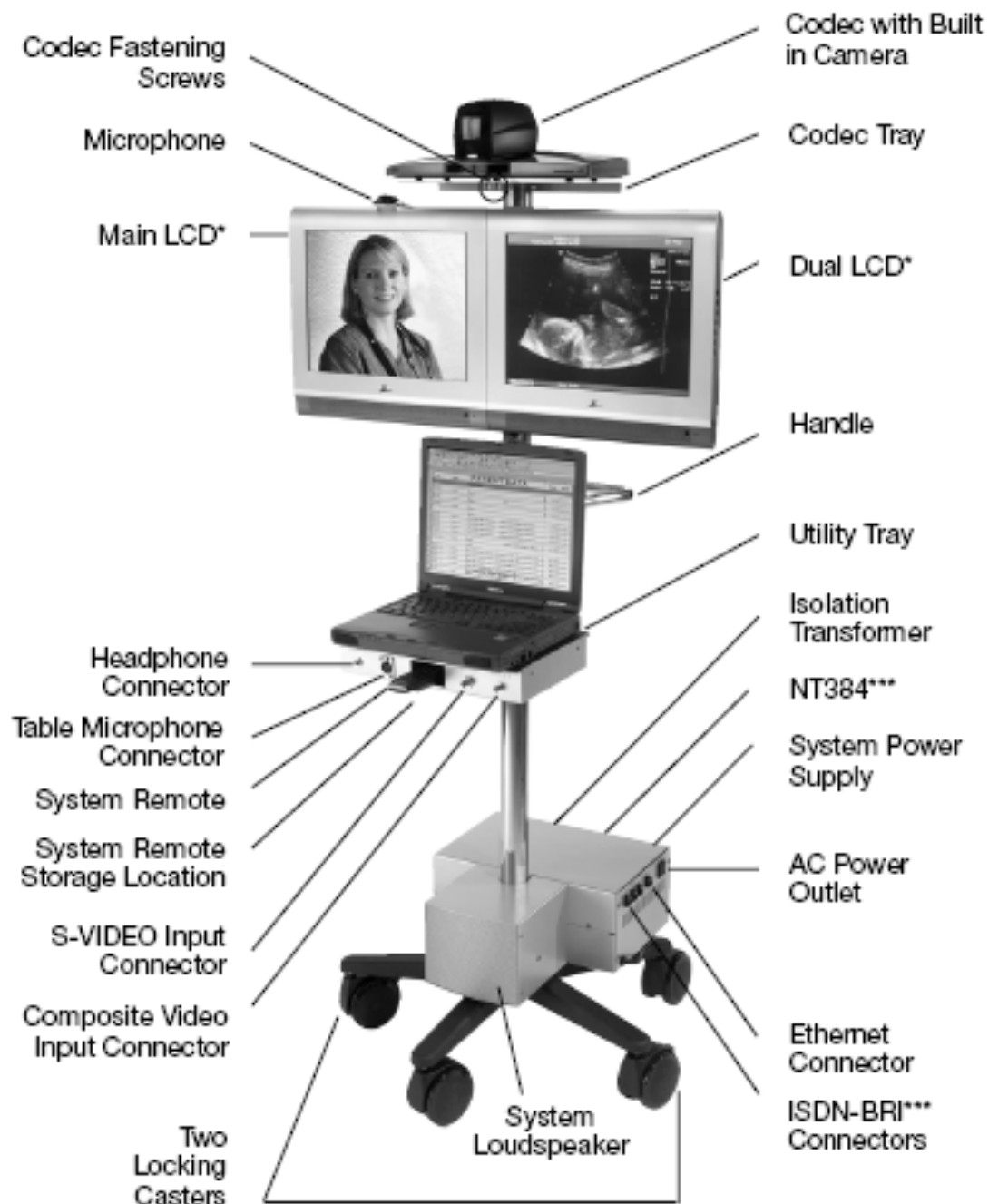


Illustration 4: CABLES, CONNECTORS, AND ADAPTERS



RCA CABLE (yellow for video; white & red for audio) and front of RCA Port



This is a BNC-to-RCA adapter used to add additional video sources or recorders.



BNC PORT --- FRONT VIEW & SIDE VIEW

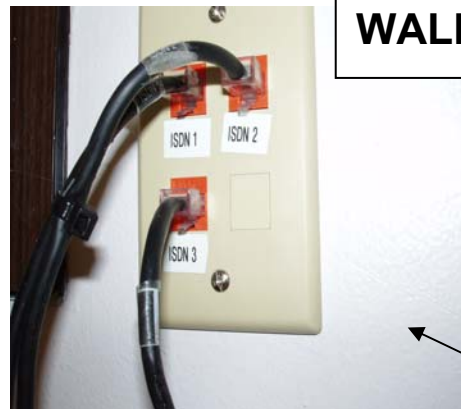


S-video port and S-video cable

ISDN CABLE



**ISDN JACKS
WALL PLATE**

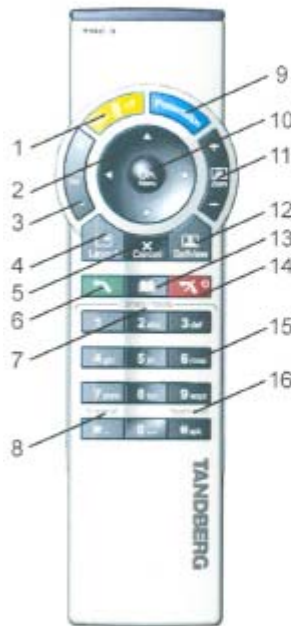


There are 3 ISDN cables labeled ISDN 1, ISDN 2, and ISDN 3 . They go from the telemedicine unit to this type of jack in the wall.

Illustration 5: THE TANDBERG REMOTE CONTROL

The Remote Control

The system is controlled with a remote control. Think of the remote control as a mobile or cellular phone with number keys and call keys. Use the arrow keys and OK to navigate the menu. The system's most commonly used functions are also accessible directly from the remote control.



1. Mic Off turns your microphone on and off.
2. Arrow keys are used for navigation in the menu and for moving the camera when the menu is hidden.
3. Volume + and - adjusts the system volume.
4. The Layout key toggles between full screen and different picture layouts.
5. Cancel takes you back one step in the menu system. Use Cancel to delete characters in an input field.
6. Press the Call key to place a call.
7. Camera presets define specific camera positions. Press and hold a number key for 1 second to save the current camera position to that number key. To activate a preset whilst in a call, simply press and release that number key.
8. Snapshot takes a snapshot of your video. (Only while you are in a call)
9. The Presentation key switches to a predefined presentation source.
10. Press OK/Menu to show the menu and to select menu items.
11. Use Zoom + and - to zoom the camera in and out.
12. Selfview displays your outgoing video. Press Selfview again to turn selfview off.
13. Store and recall your video contacts via the system Phone Book for easy placement of calls.
14. Use the red End Call key to end the current call. Pressing this key when not in a call will place the system in Standby mode.
15. Number/Letter keys function in the same manner as with a mobile or cellular phone.
16. Press Touch Tones when you are in a call and need to dial extension numbers etc. (instead of presets).

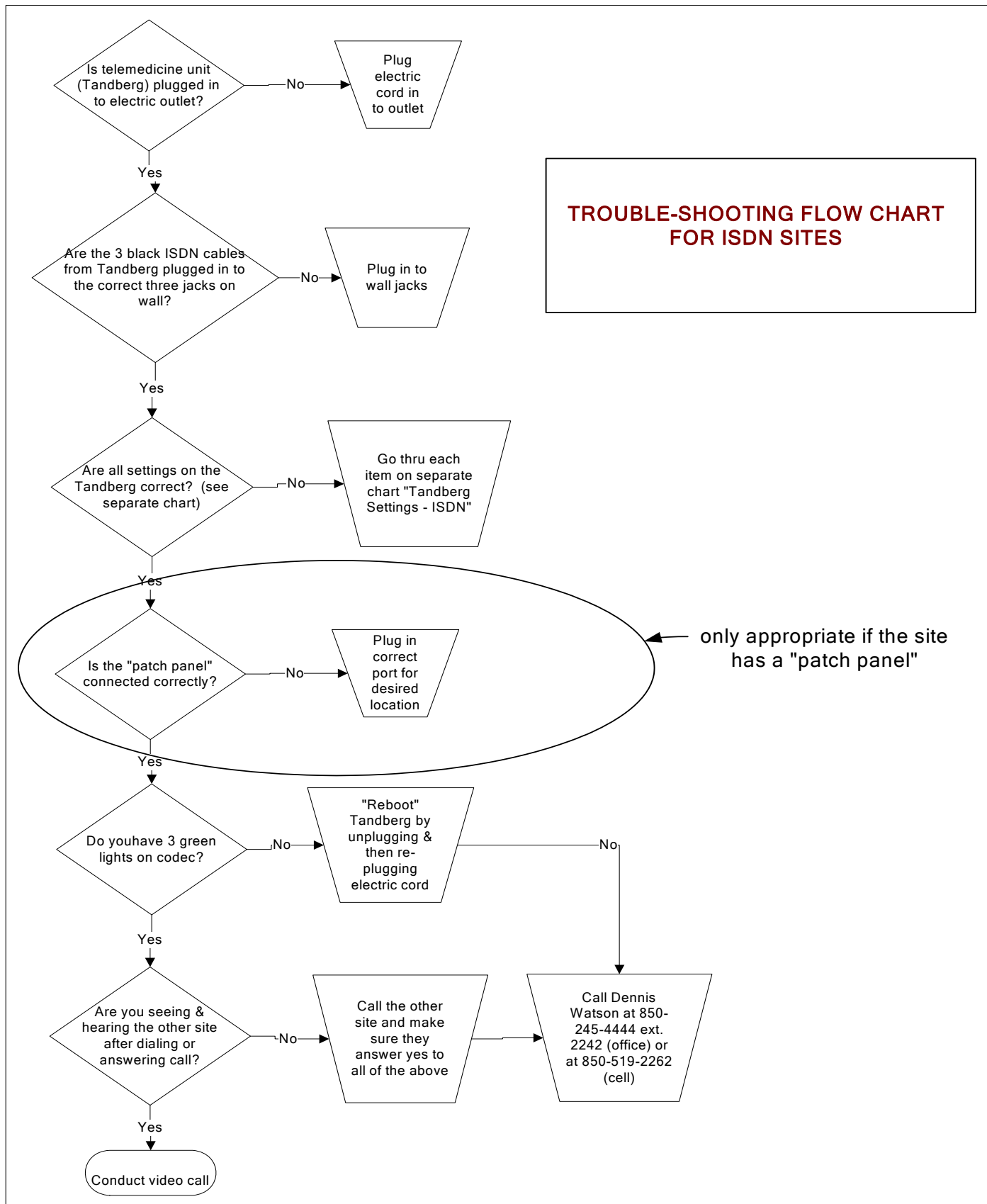
- Used to initiate call, control volume and control cameras
- The remote examiner will be able to select the video sources on the remote end that he/she wishes to see.

Making a Practice Call

- Check the NT-1 ; looking for green lights
- Watch the messages on the display
- See the other side
- Take control of far side cameras
- Let the far side take control of your cameras
- Let the far side "grab" a still image
- Use the headphones
- End the call

Reference Manuals

- ♦ The Child Protection Team Telemedicine Guidebook
- ♦ The Tandberg "User Manual"



DEFINITIONS

Listed below is a brief glossary of terms used in the CPT Telemedicine Network Guidebook.

Analog – A signal that is continuous in time and amplitude. An analog signal can take on any value, and can be used to represent qualities such as brightness and sharpness of portions of an image or the loudness and pitch of sounds.

Bandwidth - The range of frequencies a transmission line or channel can vary: the greater the bandwidth, the greater the information – carrying capacity of the channel.

CODEC – A coder-decoder that is used to convert analog signals such as video or voice into digital form for transmission over a digital medium and, upon reception, reconverts the signals to original analog form; may also perform other signal processing functions; coder/decoder, or compressor/decompressor.

Dedicated leased lines at T-1 – Refers to a digital carrier capable of transmitting 1.533 Mbps of electronic information. T-1 is a standard for transmission that is accepted in North America.

Digital – A signal that is quantified with respect to both time and amplitude. A digital signal can only take on specific values, (typically, zeros and ones) and can be used to represent samples of continuous qualities such as brightness and sharpness of portions of an image, or the loudness and pitch of sounds.

Examiner of record – Refers to the person (a physician or ARNP) responsible for directing the collection of all diagnostic information and integrating the information into a diagnosis and treatment plan. It also includes the role of maintaining the primary record.

Frame rate – Frames per second displayed on a video monitor; 25-30 frames per second (fps) is considered “full motion video.” [Note: The CPT Telemedicine Network transmits at a speed of 30 fps.]

ITU-T Recommendations – refers to a group of standards recommendations developed by the International Telecommunications Union (ITU). In general, adherence to these standards during the equipment manufacturing process ensures equipment interoperability.

H.320 encompasses a set of standards for narrow band visual telephone systems and terminal equipment, commonly used in interactive live video applications for telemedicine. Developed by the ITU, H.320 specifies technical requirements for narrow band visual telephone systems and terminal equipment, typically for videoconferencing and videophone services. It describes a generic system configuration consisting of a number of elements, definition of communications modes and terminal types, call control arrangements, terminal aspects and interworking requirements.

Informatics – The application of computer science and information science to the management and processing of data, information, and knowledge.

ISDN – Integrated Services Digital Network – digital telecommunications channel that allows for the integrated transmission of voice, video, and data, a protocol for high-speed digital transmission. Usually transmits at 64 – 128 kbps.

Hub Site – The main office for the CPT catchment area, where the CPT medical director is located. Usually, one hub site provides telehealth services to several remote sites on the telemedicine network.

Kbps – Kilobits (thousands of bits) per second – a typical compressed video clinical interaction is transmitted at 384 kbps.

POTS – Plain Old Telephone System – the analog, public switched telephone network in common use throughout the world.

Remote Site – A local site (emergency room or other facility) from which telehealth evaluations are transmitted. Usually, several remote sites communicate with experts at a single hub site.

Store and Forward – The transmission of data (e.g.; still images, video, radiographs, CT scans, MRIs, EKGs, etc.) that is captured and stored in one location (e.g.; a remote data storage device) and transferred or forwarded to another location. This enables a practitioner to give his/her opinion on a consultation without the need for simultaneous availability of both clinicians.

Telehealth – The use of electronic communications to provide or support the off-site provision of a wide array of health-related activities, such as professional continuing education, professional mentoring, community health education, public health activities, research and health services administration, as well as consultative and diagnostic health care.

Telemedicine – The use of electronic communications to provide or support clinical care at a distance.

Videoconferencing – The use of interactive telecommunications technologies which allow two or more locations to interact via two-way video and audio transmissions simultaneously.

ATTACHMENT III
REQUEST FOR APPROVAL TO IMPLEMENT CPT TELEMEDICINE PROGRAM

1. Describe the rationale for deciding to implement a CPT telemedicine program? (include a copy of the operational implementation plan and checklist described in the CPT telemedicine guide)

2. List the locations/addresses for the Hub sites:

3. Explain why Hub sites were chosen:

4. List the locations/addresses for the Remote sites:

5. Explain why Remote sites were chosen:

Implementation of a CPT Telemedicine Program reviewed by:

Contract Manager: _____

Program office technical staff: _____

Program office telemedicine liaison staff : _____

Implementation of the Telemedicine site approval by:

Division Director, Prevention and Intervention: _____

CPT TELEMEDICINE OPERATIONAL PLAN CHECKLIST

Does the CPT Telemedicine implementation include and following requirements:

Requirements	Yes	No
• Telemedicine Budget		
• Identification of the remote and hub sites		
• Internal operating procedures (IOP) for each site both remote and hub. IOP may vary for each site.		
• Identification of a local telemedicine program coordinator (to serve as a contact for administrative and/or programmatic issues).		
• Identification of a local telemedicine equipment coordinator (trained to provide 'simple' technical support in conjunction with CPT Central Office staff and others, such as with connecting equipment cables and turning on equipment); this person will participate in periodic maintenance videoconference calls and be available for troubleshooting.		
• Identification of a technical support service provider (this is a person or a service provider that will handle 'in-depth' technical troubleshooting and equipment replacement		
• Identification of a plan for backing up information collected during the telemedicine exam		
• Training plan for the CPT medical director, the telemedicine coordinator, "remote" nurse, and telemedicine equipment coordinator in the operation of the telemedicine network and equipment.		
• Training plan for the medical director or his/her designee to provide training to the nursing staff in the remote sites regarding the recognition of child physical and sexual abuse and procedures for conducting the telemedicine examination.		

ATTACHMENT IV

REQUEST FOR APPROVAL TO CHANGE TELEMEDICINE SITE OR MOVE TELEMEDICINE EQUIPMENT

TELEMEDICINE SITE:

Current telemedicine site: _____

Address of current telemedicine site:

Hub site:

Yes_____ No_____

Remote site:

Yes_____ No_____

Proposed relocation site: _____

Address of proposed relocation site: _____

Reason for request to relocate the telemedicine site:

Reason the new site was chosen:

Will the same telemedicine equipment be utilized at the new site? Yes_____ No_____

Will the relocation require additional resources? Yes_____ No_____

Will the relocation require a budget amendment to the current CPT budget? Yes_____ No_____

Will the relocation require additional staff or a change in staff? Yes_____ No_____

If yes, describe:

EQUIPMENT RELOCATION:

List of all Telemedicine equipment utilized at the current site: Manufacture name/equipment model number/serial number:

Manufacture name	Equipment model	Serial number

Is there a maintenance agreement for the telemedicine equipment at the current site: Yes_____ No _____

List of Telemedicine equipment that will be moved to a different location: Manufacture name/equipment model number/serial number:

Equipment Name/Model/Serial Number	Current Equipment Location	Relocation Site

Is there a maintenance agreement for the telemedicine equipment at the proposed new site: Yes___ No _____

Will the relocating of the site/equipment require assistance from program office staff? Yes___ No_____

If yes, list assistance needs:

Relocation of the telemedicine site reviewed by:

Contract Manager: _____

Program office technical staff: _____

Program office telemedicine liaison staff: _____

Relocation of the telemedicine site approval by:

Division Director, Prevention and Intervention: _____

Relocation of the telemedicine equipment reviewed by:

Contract Manager: _____
Program office technical staff: _____
Program office telemedicine liaison staff: _____

Relocation of the telemedicine equipment approval by:

Division Director, Prevention and Intervention: _____

Child Protection Team Telemedicine Network



Telemedicine refers to the use of electronic communication and information technologies to provide or support clinical care at a distance.

The doctor or nurse practitioner is some distance from the patient with some means of communications existing between the two sites so the examiner can see, hear, and access the patient.

The telemedicine network provides for performance of child assessments via information and computer technologies between "hub" sites and "remote" sites. Hub sites are comprehensive medical facilities with a wide range of medical and interdisciplinary staff. A physician or Advanced Registered Nurse Practitioner (ARNP) is located at the hub site and responsible for directing the medical exam. Remote sites are smaller medical facilities with limited diversity in medical and non-medical expertise. The CPT patient is seen at a remote site and a registered nurse assists with the medical exam.

Telemedicine is beneficial to many different groups, including:

- Victims of child abuse

- reducing travel time to get medical assessments
- improving access to medical expertise
- expediting child safety decisions

- Members of the community

- reducing travel time to access professional expertise
- increasing number of children receiving expert medical care in the community
- promoting partnerships

- Professionals

- reducing travel time
- increasing number of patients seen
- increasing training opportunities

Telemedicine includes **special equipment** designed to allow the transmission of live assessments between hub and remote sites. Special camera features allow professional staff viewing assessments at different locations to see external and internal physical examinations. Using this approach, the child abuse expert becomes the examiner of the record.

Network: Secure Integrated Services Digital Network operating at 384kbps transmission speed

Hardware: Tandberg Intern - with integrated computer and software for hub sites;
Tandberg Intern for remote sites

Peripherals: AMD General Exam Camera with 50x magnification; Welsh-Allyn or Leisegang colposcope

Software: Second Opinion Professional or Image Quest

For more information on telemedicine, visit www.cms-kids.com.



ATTACHMENT VI

Department of Health Strategic Plan Telehealth Workgroup Approved 2/25/08

Goals:

Identify various electronic communications and technology solutions (either currently used or appropriate for use within the department) to provide telehealth-enhanced services and information. Make appropriate recommendations to the Department of Health (DOH) standards body.

Identify laws, regulation, and reimbursement practices that serve as barriers to implementation of electronic communications related to health care.

Recommend the appropriate level of training and regulation of health care professionals necessary to protect the health, confidentiality, and safety of patients in this state.

Develop a survey tool and collect data to determine the effect of telehealth on access to health care in rural and underserved areas.

Identify gaps in service that telehealth technologies could effectively address.

Collaborate with other DOH staff to seek funding for current or planned telehealth initiatives.

Actively advocate for the thoughtful, appropriate use of telehealth technologies within and throughout the department, consistent with the department's Strategic Priorities.

Identify performance measures to evaluate telehealth initiatives.

Scope:

This workgroup will address issues relating to the need for; development of; resource attainment and allocation for; deployment of; and use of all telehealth and telemedicine projects within the Department of Health.

The role of the Telehealth Workgroup will be to provide DOH staff that are interested in using telehealth technologies with:

- Assistance in defining their telehealth need.
- Suggestions of funding resources.
- Information about other states or telehealth programs with similar goals or applications.
- Suggestions about training, implementation, and evaluation issues to address.
- Information about "lessons learned" from various telehealth projects.
- Advice regarding Health Insurance Portability and Accountability Act (HIPAA) compliance.
- Suggestions about possible technical approaches in developing telehealth projects.

For clarification, telehealth and telemedicine applications have been separated with the following sub-categories of applications included in each:

Telemedicine	Telehealth
Examples include:	Examples include:
Teleconsultations	Televisits
Telemonitoring	Distance Learning
Telehome Health	Telementoring
Teleradiology	Public Health Preparedness
Telepathology/lab	Administrative Teleconferencing
Electronic Health Record	
Medical Exams	

Guiding Principles: These guiding principles should be considered in all DOH telehealth policy development.

- * The development of a telehealth network is a cost effective and viable alternative to traditional methods of service delivery which has the potential to facilitate and enhance the delivery of information and services necessary to improve the health and safety of Florida residents.
- * Use of this technology should not be program-specific, but shared and used by all divisions of the department as well as by community partners.
- * Where applicable, telehealth enterprises should help promote state, regional, and national public health preparedness initiatives.
- * Lessons learned must be shared within the department to encourage maximum utilization of existing telehealth equipment and to assure that mistakes are not repeated.
- * All telehealth initiatives should be developed in full compliance with the Americans with Disabilities Act.
- * All telehealth information technology acquisitions must comply with the Department of Health's policies.
 - * A Patient and Family Bill of Rights, including a Release of Medical Information, must be crafted which should govern the use of this technology to assure program understanding, cooperation, and complete confidentiality and security of information.
- * Diagnostic and treatment services provided via telehealth technologies should be provided only by health care providers licensed by the state of Florida.
- * Meetings held via telehealth technologies must conform to the requirements of Florida's sunshine laws.
- * Health care services provided via telehealth technologies must fall within each practitioner's practice parameters and be HIPAA compliant.
- * Cost efficiency and cost effectiveness are crucial to consider when developing telehealth initiatives.
- * As with face-to-face encounters, health care practitioners utilizing telehealth equipment must adhere to accepted standards of practice.

Introduction

Telemedicine uses electronic communications to provide health care to persons who are at some distance from the provider. Telehealth is defined as “the use of electronic communications to provide or support the off-site provision of a wide array of health-related activities, such as professional continuing education, professional mentoring, community health education, public health activities, research and health services administration, as well as consultative and diagnostic health care.” Other definitions of telehealth include:

- All electronic means of health care communication and records management.
- The use of electronic means or devices to consult, discuss, store or inform patients and other health care practitioners with information regarding patient care.
- The electronic transfer of health information from one location to another for purposes of health promotion, diagnosis, consultation, education, and/or therapy.

With the recent advances in this technology, the quality, cost, and reliability of video, audio, and digital telecommunications have improved significantly. Advantages of this technology include rural and inner city access to specialty care, increased practitioner-patient interactions, decreased transportation costs, increased access to specialists in emergency situations, increased learning opportunities in local communities, and an opportunity for increased family participation in health care planning and management. This technology will allow a consumer’s living situation, including accessibility, to be evaluated and recommendations to be made for assistive devices and durable medical equipment and will enable case managers and technicians to interact live with rehabilitation engineers and assistive technology practitioners in other parts of the state for consultation and technical assistance. In addition, use of this technology can reduce isolation of rural, sole practitioners and can replace expensive conferences with more convenient, less expensive learning opportunities for health care providers.

In 1999, the Florida Legislature, in recognition of the increased interest and potential, as well as the potential for misuse of telehealth technologies, included Section 175 in House Bill 2125 establishing a Telehealth Task Force within the Department of Health. This task force was charged with identifying issues related to the provision of services via telehealth technologies that may impact on the health, safety, and welfare of patients and formulating recommendations to address these issues. The task force met throughout the summer and fall of 1999 and submitted a report in January 2000 to the Governor and Legislature.

Within the Department of Health, several telehealth initiatives have been implemented in the following areas: school health, diabetes, radiology, teledentistry, telepharmacy, HIV/AIDS care and treatment, evaluation of children alleged to be abused or neglected, and the care of children with special health care needs. It has become apparent that oversight of this relatively new technology is necessary in order to:

- Avoid lost time due to individual staff independently learning about the broad issues of Telehealth.
- Assure that all systems are standards-based and as integrated as possible or appropriate.
- Assist with negotiations with universities and other health care centers of excellence, to assist with grant applications or other funding mechanisms, and to stay abreast of pending legislative actions (both federal and state) regarding telehealth and telemedicine.
- Decrease duplication of effort, education, and equipment.
- Assist with planning and implementing new initiatives to avoid pitfalls commonly encountered by telehealth projects.
- Provide a central repository for training materials, standards, evaluation reports, outcomes, policies, and other information developed for or gathered by the various telehealth initiatives, both within and outside DOH.

Strategic Issues

Whenever any part of the Department of Health contemplates an initiative involving telehealth technologies, the following strategic issues should be addressed:

Licensure—All practitioners providing health care services via telehealth technologies must be appropriately licensed in Florida.

Telecommunications Infrastructure—Because video transmissions (especially real-time transmissions) require a large amount of bandwidth, each telehealth initiative should evaluate the bandwidth demands for their application. Any use of the DOH network for video transmission (both Intranet and Internet) must be coordinated with the DOH Information Technology staff. This would include potential use of the existing network connections, any proposed new network connections, use and scheduling of the videoconferencing bridge, need for network technical assistance, and need for training. Additionally, since telehealth involves the electronic transmission of health care data, issues regarding whether and how to record and store this data are relevant.

Technical Assistance—Each project should identify how local and statewide (if needed) technical support will be procured. This step should include identification of the projected time needed for technical assistance and support from both a local and statewide basis.

Equipment Procurement—All telehealth equipment procurements should adhere to the department's Information Technology Governance policy. This policy establishes the basic organizational framework for governing the development, acquisition, and use of information technology resources within the Department of Health. Governance and its associated processes ensure delivery of information technology to the Department of Health that supports the department's priorities.

Cost of Service Delivery—One of the major obstacles in the deployment of telehealth and telemedicine technology is the lack of third party reimbursement for health care services provided via this technology in Florida. Each project should address funding streams available for reimbursement for health care services, for equipment and network maintenance, and for technical support and ongoing training. Maximum equipment usage, including multiple service applications, should be considered for all telehealth initiatives.

Confidentiality and Security—Each project should address how patient information obtained or shared via telehealth technologies will be protected and comply with the department's Security, HIPAA, and related policies.

Community or Provider Support—It is imperative that local "buy-in" from participating partners be obtained early in the planning stage of any new telehealth initiative. All potential users should be included in the planning process and a written agreement clearly defining roles and responsibilities of each participant should be completed prior to implementation.

Regulation—Since telehealth is a relatively new tool, existing statutes and rules may not recognize telehealth.

Glossary:

1. **Americans with Disabilities Act:** Prohibits private employers, state and local governments, employment agencies and labor unions from discriminating against qualified individuals with disabilities in job application procedures, hiring, firing, advancement, compensation, job training, and other terms, conditions, and privileges of employment. An individual with a disability is a person who has a physical or mental impairment that substantially limits one or more major life activities; has a record of such an impairment; or is regarded as having such an impairment.

2. **Distance Learning:** Education delivered through distributed resources—content, instructor, student, and technology—in different, non-centralized locations allowing instruction and learning to occur independent of time and place. It can be used in combination with traditional classroom-based courses and traditional distance learning courses or to create wholly virtual classrooms.
3. **Electronic Health Record or Computer-Based Patient Record:** Electronically maintained information about an individual's lifetime health status and health care. This record replaces the paper medical record as the primary source of information for health care meeting all clinical, legal, and administrative requirements. It is seen as a virtual compilation of non-redundant health data about a person across a lifetime, including facts, observations, interpretations, plans, actions, and outcomes. This system captures, stores, processes, communicates, secures, and presents information from multiple disparate locations as required.
4. **HIPAA:** Health Insurance Portability and Accountability Act. Signed by President Clinton on August 21, 1996, it addresses both insurance coverage during a change of employment as well as confidentiality requirements for all health care related information regarding a patient.
5. **Information Technology Governance:** IT Governance is designed to maintain an agency-wide (enterprise) perspective in the planning and management of information resources within the Department of Health. The Governance process will assist in the development of the department's strategic goals and objectives, legislative budget requests, policies, procedures, and technology standards.
6. **Real-time or synchronous transmission:** Situation where parties on both or all ends of the connection are interacting live. Data acquisition, processing, and presentation are all occurring simultaneously in a system.
7. **Store and forward:** The transmission of data (e.g., still images, video, radiographs, CT scans, MRIs, EKGs, etc.) that is captured and stored in one location (e.g., a remote data storage device) and transferred or forwarded to another location. This enables a practitioner to give his/her opinion on a consultation without the need for simultaneous availability of both clinicians.
8. **Teleconferencing:** An interactive communication involving exchanges of voice, video, and data between people at two or more sites that is made possible by using telecommunications systems.
9. **Teleconsultations:** Health care consultations in which the participants are separated by geographical distance and also may be separated in time.
10. **Telehealth:** "The use of electronic communications to provide or support the off-site provision of a wide array of health-related activities, such as professional continuing education, professional mentoring, community health education, public health activities, research and health services administration, as well as consultative and diagnostic health care."
11. **Telemedicine:** The use of electronic communications to provide or support clinical care at a distance.
12. **Telementoring:** The use of telecommunications media to provide individual guidance, instruction, or peer support.
13. **Telemonitoring:** The use of telecommunications media to monitor the health status of patients at a distance.
14. **Teleradiology:** A system that transmits images over a distance, using leased or switched transmission lines.
15. **Televisits:** The use of two-way video and audio transmission to provide ongoing provider contact for clients and families; for the purpose of facilitating emotional/social supports for clients who are separated from

family/friends for long periods; and to enhance peer contact for remote providers or with providers with very specialized jobs.